I: State Information

State Information

Plan Year

Start Year:
2012

End Year:
2013

State DUNS Number

Number
949088447

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
California Department of Alcohol and Drug Programs

Organizational Unit
Division of Administration - Grants Management Office

Mailing Address
1700 K Street, 5th Floor

City
Sacramento

Zip Code
95811-4037

II. Contact Person for the Grantee of the Block Grant

First Name
Michael

Last Name
Cunningham

Agency Name
California Department of Alcohol and Drug Programs

Mailing Address
1700 K Street, 5th Floor

City
Sacramento

Zip Code
95811-4037

Telephone
916-445-1943

Fax
916-324-7338

Email Address
Michael.Cunningham@adp.ca.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2009

To
6/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
Allen

Last Name
Scott

Telephone
916-324-8903

Fax
916-324-7338

Email Address
Allen.Scott@adp.ca.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Diana S. Dooley
Title	Secretary
Organization	California Health and Human Services Agency

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Diana S. Dooley
Title	Secretary
Organization	California Health and Human Services Agency

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that California will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	Diana S. Dooley
Title	Secretary
Organization	California Health and Human Services Agency

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

INTRODUCTION

The California Department of Alcohol and Drug Programs (ADP) welcomes the retooling of the Substance Abuse Prevention and Treatment (SAPT) Block Grant application as a necessary adaptation to the passage of the federal Patient Protection and Affordable Care Act (ACA).

For the substance use disorder (SUD) field, the ACA has opened multiple policy windows. Specifically, the inclusion of SUD services as an essential health benefit testifies to the value of these services in achieving general health and wellness. As the ACA proceeds on a fast track to 2014, ADP looks to building collaborative partnerships across all sectors and systems to fully realize the promise and potential of health care reform. In California, the Department of Health Care Services, the single state agency (SSA) for California's Medicaid program, known as Medi-Cal, leads the rollout of ACA implementation. The California Department of Mental Health (DMH) and ADP are working closely with DHCS to ensure that integration of mental health and SUD services into primary care is a top priority for California.

Section 1115 Medicaid Waiver

California is currently at a significant crossroads in behavioral health with the approval of its Section 1115 demonstration waiver project, entitled "California's Bridge to Reform," in November 2010. Administered by the California Department of Health Care Services (DHCS), the goal of the 1115 waiver is to create more accountable, coordinated systems of care with an initial focus on enrolling seniors and persons with disabilities (SPDs) into managed care. The waiver will then implement integrated care models for dual eligibles[1], as envisioned by the ACA. The 1115 waiver's implementation plan is organized around the four principal vulnerable Medi-Cal populations and the programs that serve them in California:

1. SPDs;
2. Persons with Dual Medi-Cal and Medicare Eligibility;
3. Children with Special Health Care Needs; and
4. Persons with Behavioral Health Disorders and/or Substance Use Requiring Integration of Care

The 1115 waiver addresses the delivery of health care for the populations that are the most medically vulnerable, highest-cost, highest need and require the most coordinated care of all Medi-Cal beneficiaries. These beneficiaries are those with complex chronic conditions and co-morbidities. The 1115 waiver will result in improved integration of behavioral health and physical health care for these populations.

The 1115 waiver also immediately expands coverage today for those who will become "newly-eligible" in 2014 under the ACA. Finally, the 1115 waiver will tests various strategies designed to strengthen and transform the state's public hospital health care delivery system for the additional numbers of people who will access health care once the ACA is fully implemented. In addition to the 1115 waiver renewal, in September 2010, two California

[1] Individuals who are enrolled in both Medicare and Medicaid are called dual eligible.

bills were signed into law, which together created the framework for the California Health Benefit Exchange. California was the first state to form a board to oversee the implementation of its health insurance exchange after the passage of the ACA. Coupled with the 1115 waiver demonstration project, California is at the forefront of national health care reform and may serve as a model for other states beginning their health care reform planning.

The 1115 waiver is expected to increase and expand health care coverage to as many as 500,000 low-income uninsured residents by taking advantage of the Coverage Expansion and Enrollment Demonstration (CEED) offered in the ACA. The CEED project builds upon the county-based health care coverage initiative (HCCI) formed in the previous 2005 Medicaid hospital financing 1115 waiver. County-based low-income health programs (LIHP) will be provided to two groups: the Medicaid Coverage Expansion (MCE) population and the HCCI population. Eligible adults will be enrolled in a medical home and receive a core set of services, including inpatient and outpatient services, prescription drugs, mental health (MH), and other medically necessary services. The 1115 waiver immediately begins phasing in coverage for the MCE population, which comprises “newly eligible” adults from ages 19 to 64 with incomes up to 133 percent of the federal poverty level (FPL), who are not otherwise eligible for Medicaid. The 1115 waiver also offers coverage for the HCCI population, which includes adults with incomes between 134 and 200 percent of the FPL, who beginning in 2014 will receive coverage through the Exchange.

The 1115 waiver does not mandate SUD services in the county-based LIHPs. However, counties can elect to provide SUD services in the LIHP benefit package if they provide the non-federal share of cost to receive the federal matching reimbursement. Several counties already include a range of SUD services in their LIHPs: Kern, Orange, Riverside, San Francisco, San Mateo, Santa Clara, Santa Cruz, and Tulare. As the 1115 waiver expands coverage to single, childless adults, these individuals will seek basic medical care in primary care settings. Many in this predominantly young adult population (less than 40 years old) are expected to need SUD services. The future delivery of SUD treatment services beginning in 2014 will increasingly involve referrals from physicians outside the traditional SUD system. The 1115 waiver is an opportunity to begin integrating SUD and primary care now by allowing counties to provide SUD services in their LIHP benefit package.

Integration of mental health and addiction services into primary care is a top priority for California. ADP is collaborating with the University of California, Los Angeles—Integrated Substance Abuse Programs (UCLA-ISAP), to advance its planning and strategizing efforts for integration while awaiting further guidance on the "essential health benefit" package from federal agencies (This effort will be further discussed later.). In years two and three of the five-year 1115 waiver, there will be increased focus on the overall behavioral health delivery system. Specifically, the 1115 waiver’s Special Terms and Conditions require:

- Behavioral Health Services Assessment - By March I, 2012, the State will submit to the Centers for Medicaid and Medicare Services (CMS) for approval an assessment of available mental health and SUD service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and

other information necessary to determine the current state of behavioral service delivery in California for Medi-Cal beneficiaries.

- Behavioral Health Services Plan- By October I, 2012, the State will submit to CMS for approval a detailed plan, including how the state will coordinate with the DMH and ADP outlining the steps and infrastructure necessary to meet requirements of a Medicaid benchmark plan no later than 2014.

State-County Realignment of Public Services

California's early implementation of the ACA, through its section 1115 Medicaid waiver, as well as enabling legislation for a state health insurance exchange, facilitates the State's readiness for the expected increased demand for SUD services as coverage expands in 2014. However, at the time of this writing, several factors impact the existing SUD service system. The economic recession has had a disproportionate impact on California's finances, resulting in a reduction in dedicated state resources for SUD services over the past few years. This includes the loss of significant funding to serve the criminal justice population. In Fiscal Year (FY) 2009-2010, dedicated state funding for the Substance Abuse and Crime Prevention Act of 2000 (SACPA), a diversion program for offenders enacted by California voters via Proposition 36, was eliminated. However, the requirement to serve this population remains in effect. The budget for FY 2010-2011 further reduced dedicated funding for the offender population.

In an effort to ensure the continued availability of vital public services that include mental health and SUD services, the Administration and Legislature recently have begun to implement a solution that fundamentally restructures the state-county relationship. Dubbed "Realignment", the FY 2011-12 Budget Act redirects a portion of the state sales tax and the vehicle license fee directly to counties in lieu of General Funds (GF). The objective of Realignment is to shift a share of revenue directly to counties along with the primary fiscal responsibility for operating public safety and health programs.

County health systems are responsible for managing multiple state- and federally-funded health programs with varying policies, professional standards, eligibility rules, program requirements, reporting protocols and data systems. Under Realignment, counties would gain authority, flexibility and greater cost-effectiveness in administering health care services, including increased local control to prioritize funding according to community needs. The State's role under Realignment is refocused on appropriate oversight, technical assistance (TA), and monitoring outcomes. Realigned funds for SUD will support the following programs and services: Non Drug Medi-Cal; Drug Court Programs; and the Drug Medi-Cal (DMC) (Medicaid) Program. One caveat applies to DMC. As a state-federal Medicaid program, DMC is more proscriptive and offers fewer avenues for "local" control due to federal Medicaid rules.

Another key component of California's Realignment that impacts the SUD service system is the transfer of short-term, lower-level adult offenders from state prisons to local jurisdictions. Realignment would increase resources at the local level so offenders meeting these criteria could be more effectively managed with a combination of probation services and jail time to

increase successful outcomes in re-entering society. Realignment also shifts adult parole to the counties. Increased opportunities to provide parolees more services, including mental health and SUD services could increase parolee success in rehabilitation. With program responsibility at the local level, counties could implement creative models of integrated services for the new probation population and for those who suffer from co-occurring mental health and SUDs, as well as other low-income persons currently receiving treatment services.

Transfer of State Functions

In addition to realigning funding for SUD services, the FY 2011-12 Budget Act also consolidates state support functions for DMC and two community mental health services programs administered by DMH— the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program, and Mental Health Managed Care (MHMC)—under a single state department—the DHCS. These program transfers to DHCS must be effective no later than July 1, 2012. All three of these programs are components of Medi-Cal. These three programs are commonly referred to as "carve-outs," because they are not a part of the Medi-Cal Program administered by DHCS, which provides medical services such as doctor visits and inpatient hospital care to mainly low-income persons. Historically, ADP has administered the DMC program through an interagency agreement with DHCS. The Administration indicates that while the State will continue to have important oversight functions and administrative responsibilities, it is no longer essential to have separate departments administer the realigned programs.

The DHCS reorganization is designed to create increased efficiencies within state and local programs, and prepare California for ACA implementation. The Administration states many benefits for this reorganization, some of which include:

- Improves access—provides a single point of contact and a stronger centralized voice for behavioral health policy and program coordination, development implementation and monitoring as well as problem resolution;

- Places California in a stronger position to advocate for greater parity of behavioral health with physical health;

- Supports health care reform and the integration of substance use disorders with primary care and mental health by consolidating these services in DHCS, the department responsible for primary care and overall health care delivery; and

- Supports the federal government's effort to encourage integration of mental health and substance use care. The new guidelines for the SAMHSA block grant application require states to explain how they will address and integrate co-occurring disorders.

Challenges and Opportunities

Amidst ongoing developments with the State's 1115 waiver, the state-county realignment of public services, and the transfer of state functions, there are several unknowns. These

include maintaining an appropriate level of funding to support realigned programs, the extent of state-level authority in a realigned SUD service system, and the way a reorganized DHCS will coordinate its efforts in Medi-Cal with SAPT Block Grant funded programs and services. Simultaneously facing challenges and promising opportunities, ADP stands ready to prepare the SUD field for participation in the high performing health care systems envisioned by the ACA.

ADP believes through several of its strategic initiatives, California has laid the necessary foundation to meet the new SAPT Block Grant requirements and impending ACA mandates. One such initiative is the Continuum of Services System Reengineering (COSSR) effort, a significant, multi-phase system improvement initiative to re-engineer California's continuum of services (COS) for SUD problems. The foundation of this initiative lies in the acknowledgement that alcoholism and drug addiction are the result of a chronic brain disease and that a new, integrated system of care is necessary in order to achieve the desired outcomes for prevention, treatment, and recovery for those individuals and communities served by the SUD field.

This new system of care requires integration and coordination from the many stakeholders working in the SUD field working in prevention, treatment, and recovery support services, as well as, partners in mental health, health care, law enforcement, social services, and education. Presently, the COSSR project is conducted in partnership with counties and other public/private stakeholders. ADP's COSSR effort calls for a streamlined and coordinated COS that is responsive to individual client needs, accurately measures performance and outcomes, and results in improved data collection and accountability. For these reasons, COSSR is very much in accordance with SAMHSA's model for a "Good and Modern Addictions and Mental Health Service System."

The Changing Health Care Environment

To complement COSSR, ADP has obtained the services of UCLA-ISAP for a project titled, "Evaluation Services to Enhance the Data Management System in California (ENCAL)." ADP and researchers from UCLA-ISAP work to understand the implications of SUD and primary care integration as it relates to the ongoing work at the state level around providing a full continuum of services. ENCAL has specific objectives to prepare counties and providers for integrating SUD services with primary care and mental health services. These include:

- Assessing existing integration models and local and national integration efforts;
- Assisting integration planning through learning collaboratives; and
- Evaluating integration environment and learning collaborative processes and outcomes.

To achieve these objectives, ADP and UCLA have conducted literature reviews of studies of models of integrated behavioral health care, surveyed California counties, conducted exploratory site visits of federally qualified health centers (FQHCs), performed descriptive case studies of county integration efforts, and established an information resource website to house "must see" literature, presentations, and reports from national integration efforts.

ADP and UCLA also recently presented a public information event, “Forum on Integration: Integrating SUD Services and Primary Care.” The Integration Forum brought together policy makers, program administrators, provider group representatives and researchers from across California and the nation to:

1) Discuss the role of the public SUD treatment system in the integration of behavioral health and primary care services;

2) Learn about models of SUD/primary care integration currently being implemented throughout the United States; and

3) Set an agenda for moving ADP and California counties toward integration with physical health services.

Through the Integration Forum, the Integration Survey, and the case studies and site visits, it became clear that counties were in need of TA and training on topics related to integration. Areas of need include: how to develop partnerships with primary care providers; which integration model works best in which settings; how to fund integration pilots; and how to adapt SUD services to fit health care settings.

ADP has also established the Statewide Needs Assessment and Planning (SNAP) process to institute system improvements through development of a data-informed planning and decision-making process. These three initiatives—COSSR, ENCAL, and SNAP—will guide California in fulfilling the new SAPTBG requirements.

The Department has long recognized the responsibility of leading the SUD field in implementing a culturally and linguistically competent prevention, treatment and recovery continuum of care. In 2010, the Department committed to improving cultural and linguistic competency in the business functions that support key strategic areas as well as outcome-based planning and accountability. Through an extensive and fast-track planning process, the Department adopted the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health, U.S. Department of Health and Human Services, as the guide for developing a Cultural Competency Quality Improvement Strategic Plan to support CQI in our service delivery system. This Plan supports the Department’s Vision, Mission, Core Programs, overall Strategic Goals and the implementation of the Continuum of Services System Re-engineering (COSSR) Project. The current Plan will help to ensure the highest quality of care for diverse communities within California.

Statewide Needs Assessment and Planning (SNAP)

As previously indicated to SAMHSA, the State awaits the completion of its Behavioral Health Needs Assessment. The 1115 waiver’s needs assessment may contain pivotal information that will help California fill in gaps in the data and literature relating to its behavioral health system. This information will allow ADP to more effectively incorporate the needs and priorities of special populations, the changing health care environment, and SAMHSA’s strategic initiatives into its existing SNAP process.

SNAP is based on the strategic planning framework and is modeled after the Strategic Prevention Framework (SPF). SNAP includes assessment, planning, capacity building, implementation, and evaluation. SNAP encompasses both prevention and treatment. The State Epidemiologic Workgroup (SEW), led by ADP's Office of Applied Research and Analysis, also includes California Department of Public Health epidemiological staff. The SEW contributes data and analysis to the SNAP epidemiological profile for both prevention and treatment.

The purpose of ADP's SNAP process is to institute system improvements through development of a data-informed planning and decision-making process. The state-level process for data informed decision-making will support local planning efforts by providing counties with timely information and allow the state and county agencies to communicate and collaborate more effectively in the planning and assessment process. Through in-person discussions and using online tools, ADP envisions working with the counties to jointly review data and develop plans to respond to county and statewide needs.

The 2011 SNAP process has identified the following state priorities:

Priority 1: Increase Health Care Reform Readiness

Priority 2: Build Capacity for Early Intervention Strategies

Priority 3: Employ More Science-Based Prevention Strategies

Addressing the Needs of Diverse Racial, Ethnic, and Sexual Gender Minorities, as well as Youth who are Often Underserved

The aforementioned State priorities focus on system improvement and infrastructure development. Notably, implementation of these priorities would reform California's continuum of SUD services to more closely reflect the "good and modern" system articulated by SAMHSA. However, the three priorities do not explicitly mention special populations, for which the new SAPTBG application requires states to develop planning activities. Prior to this application, California has long recognized its responsibility for ensuring the availability and accessibility of effective, efficient, culturally competent services. This long-standing commitment toward meeting this responsibility is driven by the needs of California's culturally and linguistically rich population, including those who will be newly covered for behavioral health services through the ACA. ADP's multi-year commitment toward serving populations that experience disparities in health care is illustrated through technical assistant (TA) contracts with culturally competent providers who specialize in serving these populations. These TA contracts focused on the unique needs of the following communities: African-American, Asian/Pacific Islander, Hispanic, Lesbian, Gay, Bisexual, and Transgender (LGBT), Native Americans, aging individuals, persons with disabilities, pregnant and parenting women, and youth.

Further, ADP's 2006-08 Strategic Plan included state imperatives for addressing the unique needs of special populations:

- "Goal 10: Develop strategies to plan and support culturally appropriate services.

- Strategy 10.1: Conduct needs assessments and develop cultural competence management strategies.
- Strategy 10.2: Develop and implement a cultural competence program and service guidelines."

This culminated in ADP's development of a Cultural Competency Quality Improvement (CCQI) Strategic Plan for 2010-12, which identifies and adopts the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services. It provides direction and guidance for the SUD treatment field on strategies to plan and support culturally appropriate services. The CCQI plan enunciates ADP's commitment to reducing disparities within California's SUD service system by including cultural proficiency requirements in contracts with SUD providers that receive state and federal funds. CCQI is also specifically integrated into COSSR as described in the following COSSR Project outcomes statement:

- "A comprehensive and integrated continuum of alcohol and other drug services. The services are effective, high quality, client and community centered, sustainable and culturally competent. They have the capacity and resources to facilitate holistic health and promote wellness."

Overall, the CCQI plan furthers ADP's vision, mission, core programs, overall strategic goals and implementation of the COSSR effort. Building on the momentum of the CCQI plan, ADP has also recently launched its Community Alliance for CLAS project, which focuses on achieving long-term cultural proficiency in the SUD field. To do so, the project will evaluate CLAS readiness of SUD service agencies and establish a framework for capacity building using the federal OMH CLAS standards and other evidence-based cultural competency models. Key components of this project include: establishing a multidimensional community outreach and education campaign to raise awareness of the profound benefits of cultural and linguistic proficiency, and development of a broad community and consumer-involved assessment, TA, and evaluation approaches. Equally important, this project will establish for participating agencies performance indicators and measurable specific objectives for CLAS enhancements, as well as prepare participants for adoption and integration of self-assessment policies and procedures.

ADP also includes representatives from traditionally underserved populations to serve as advisors in policy forums. These forums actively solicit these communities' participation in statewide policy and program development. ADP also conducts ongoing cultural and linguistic competence training for state staff, as well as provides cultural and linguistic competence TA and training contracts for SUD providers.

Based on ADP's prior leadership, California is well positioned to meet the new SAPT Block Grant requirements pertaining to planning activities for special populations with unmet needs.

This application will discuss the following required and optional populations:

- Individuals who are intravenous drug users*
- Adolescents with substance use problems
- Women who are pregnant and have a substance use and/or mental disorder*
- Parents with substance use who have dependent children*
- Military personnel (active, guard, reserve, and veteran) and their families
- Individuals with tuberculosis*
- Individuals with or at risk for HIV/AIDS and who are in treatment for substance use*
- Individuals with SUDs who are homeless
- Individuals with co-occurring disorders
- Individuals involved in the criminal justice system
- Underserved racial and ethnic minority and LGBTQ populations

In its Needs Assessment Report (NAR), ADP's 2010 SNAP process has also identified State target populations, some of which overlap with the list above. The NAR includes suggestions for future areas of improvement. Formal state priorities were not developed around these state target populations due to insufficient data. The hope is to obtain more complete data from the 1115 waiver's needs assessment to better inform the needs assessment and subsequent planning efforts. SNAP recommendations from the 2010 NAR are as follows:

- To address overall need:
    - Target youth aged 12 through 20 for evidence-based universal prevention strategies
    - Target youth aged 16 and 17 years old for evidence-based selective prevention strategies
    - Target young adults aged 21 through 25 for evidence-based early intervention strategies
    - Target youth aged 18 through 25 for evidence-based prevention, early intervention, and treatment services
- Complete an in-depth analysis of race/ethnicity data to understand its relationship to the SUD service needs in California to inform program decisions

- Consider instituting programs to increase the treatment capacity for the following subpopulations in the listed order:
    - Veterans
    - Individuals with co-occurring disorders
    - Pregnant women
    - Homeless individuals

* SAPTBG Required Population

Also included here are the responses to the common areas for DMH and ADP, as requested in the application materials:

Bi-directional Integration of Behavioral Health and Primary Care Services

There have been conversations at the state and county level in California regarding the need to integrate and create a "no wrong door" set of policies on health care access for over a decade. Counties with combined substance use and mental health treatment systems have been collaborating with each on small scale pilots and initiatives as part of "systems of care" development. With growing recognition of the national conversations, in 2008 the California Institute for Mental Health (CIMH) began the Integration Policy Initiative (IPI); a collaborative project with the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). Funded by The California Endowment and IBHP, the project was developed to address the pressing need for improved linkages between the mental health, substance use and physical health care systems serving California's safety net population. The goals were to:

1. Develop a set of policy recommendations enhancing the interface between behavioral health and primary (physical) health care;

2. Share the recommendations with local and state policy makers; and

3. Accelerate systems (bi-directional) integration.

The vision of the IPI is: "Overall Health and Wellness Is Embraced as a Shared Community Responsibility."

In the fall of 2009 ADP began to reconfigure TA efforts with counties and providers to orient the field at scale on the concepts of integrated health care models, employing the services of UCLA–ISAP. Working through various advisory groups and the county administrators' quarterly meetings, ADP provided a sequenced set of trainings to educate our stakeholders on effective models and critical program components of integrated care. This work has continued through 2010, as ADP continued the TA to provide greater detail on integration approaches with primary care, including a learning collaborative and regional sessions.

This work highlights new areas of concern, such as sharing of client records. ADP is leading efforts to seek TA directly from SAMHSA on confidential client record sharing across mental health and SUD systems of care for persons with co-occurring disorders. Similarly, the California Mental Health Director's Association and CADPAAC have requested training and TA from SAMHSA independent of SSAs about data sharing across health care systems to address behavioral health and primary care in the new electronic era.

Finally, California has begun a state reorganization of the DHCS, DMH and ADP. The proposed reorganization is designed to create increased efficiencies within state and local programs, and prepare California for implementation of the ACA. The current Administration sees many benefits for consumers, other stakeholders, counties, and the State, including an emphasis on bi-directional integration.

For consumers and stakeholders this reorganization:

- Improves the coordination, development and delivery of policies, programs and services for effectively dealing with co-occurring disorders.
- Improves access—providing a single point of contact and a stronger centralized voice for behavioral health policy and program coordination, development, implementation and monitoring as well as problem resolution.
- Places California in a stronger position to advocate for greater parity of behavioral health with physical health.
- Improves outcomes and provides better quality assurance, accountability and focus on professionalism of the caregiver/provider community and the counties that oversee them.
- Strengthens the platform and voice for the Consumer/Family Member networks as this consolidation will provide them a significantly stronger centralized, coordinated platform for input into state and federal decisions regarding behavioral health program and policy coordination, development, implementation and monitoring.
- Supports the movement towards integrating access to “health care homes” that offer comprehensive care management for Medi-Cal beneficiaries.
- Improves the ability to coordinate services for SUDs and mental health disorders with those for other physical conditions, thereby improving patient care for co-occurring conditions or disorders.

For counties and the State this reorganization:

- Provides a stronger and more focused state interface with the federal government during communications regarding our waiver and state plan amendments to appropriately integrate the rehabilitation, recovery, and resiliency model with existing federal requirements.
- Communicates a clear and consistent culture of accountability from the SSA (as opposed to having the different cultures of DMH and ADP interpreting and implementing Medi-Cal policy separately from DHCS, program development, implementation, monitoring, and sanctions in different ways).
- Supports health care reform and the integration of SUDs with primary care and mental health by consolidating these services in DHCS, the department responsible for primary care and overall health care delivery.
- Supports health care reform and the federal government’s effort to encourage integration of mental health and substance use care. The new guidelines for the SAMHSA block grant application require states to explain how they will address and integrate co-occurring disorders.
- Provides a coordinated approach to dealing with potential waste, fraud, and abuse of Medi-Cal funds, which will reduce duplication of functions, costs, and confusion.
- Improves alignment with many behavioral health administrative structures at the county level, as many California counties already function administratively with consolidated mental health and alcohol/drug programs.
- Provides counties with a significantly stronger single point of contact and therefore, a more effective and efficient avenue for their input into state and federal deliberations

and decisions regarding behavioral health program and policy coordination, development, implementation, and monitoring.
- Increases administrative and operating efficiencies at the state level.
- Increases the state's ability to address the infrastructure components of health care reform including electronic health records, complex billing, and data collection systems.

Provision of Recovery Support Services for Individuals with Mental or Substance Use Disorders

ADP Response

ADP is committed to the development, maintenance, and continuous improvement of a comprehensive and integrated continuum of public SUD services system based on acknowledging both the acute and chronic nature of SUD problems and addiction. Fundamental to this system is the recognition that addiction causes problems that are of a continuous, chronic, and relapsing nature for both individuals and communities, necessitating continuing care and support. It is essential to recognize the negative impacts of SUDs to other systems such as child welfare and foster care, criminal justice, mental health, and primary care in making the case for SUD prevention and treatment

Viewing substance dependence and addiction as a chronic disease has required a shift in thinking about current SUD service systems and acknowledges the necessity of a new, integrated system of care in order to achieve desired outcomes for the prevention, treatment, and recovery. This new system of care requires integration and coordination from the many stakeholders in the SUD field working in prevention, treatment, and recovery support services, as well as partners in mental health, primary health care, law enforcement, social services, and education.

ADP continues to emphasize COSSR in examining the current SUD services delivery system. The primary goal of the re-engineering process is to work with ADP's stakeholders to reshape and reposition ADP's operations to ensure system accountability, efficiency, and effectiveness, while delivering comprehensive, high-quality SUD services within the framework of a public system of services.

The Continuum of Services model contains the following elements:

- Intervention may occur at all levels in the continuum.
- Coordination of services within the SUD services model and with other service providers is a critical component of a successful system of care.
- All SUD services provided within the system should be sustainable, integrated, culturally competent, and evidence-based.

This recovery support services model formally acknowledges both the acute and chronic nature of SUD problems and represents a newer perspective of substance use and dependence as a chronic condition across systems.

DMH Response

DMH has a long history of supporting recovery activities with mental health services and supports. Since the passage of the Mental Health Services Act (MHSA), this has become more specific in the development of counties' plans and DMH has emphasized recovery and wellness for all mental health services.

Clients and families have become integrated into the county planning processes and for input in some of the Medi-Cal activities such as program compliance reviews. Another way that DMH includes clients and family members is through a federal and state mandated advisory council. The California Mental Health Planning Council (CMHPC) has a long history going back to 1960 in advising DMH, and representing and advocating for the interests of those served by the department. The council operates independently from the DMH to provide public input into mental health policy development and planning. The current entity, the CMHPC, was established in state statute in 1993 in response to the realignment of mental health program responsibility and funding. In addition to establishing a dedicated funding base for mental health services, realignment provided county governments with greater autonomy and flexibility in managing their local mental health programs. The Planning Council was designed to be an appropriate structure for public input, planning, and evaluation under realigned mental health programs.

DMH recently adopted an updated strategic plan for 2009-2014 which will carry that department through current changes and the upcoming effects of health care reform. It emphasizes strength based wellness with the goals of: improving outcomes, enhancing public safety, investing in change, ensuring accountability, and empowering people.

Combined (ADP/DMH) Plan for Expenditure of Funds for COD Services

California's state departments for SUD and mental health have effectively managed the various federal funding streams designated for specific components of the overall behavioral health systems. It has been recognized that this management of federal funds from multiple institutions has created separate and distinct systems of care for mental health and SUDs. In attempts to improve coordination, the majority of counties structure both systems under a behavioral health organizational model. Even though the county mental health and alcohol and drug agencies often remain separate programs under the same roof, there is improved communication on co-occurring disorders (COD) services and funding. This is evidenced by the work of both county associations and providers, who emphasize the importance of COD clients and funding options though their committee work and advocacy for funding. It is also emphasized locally where county financing options for these services continue to be designed for the most effective use of funds, and organized around cost centers that attempt to improve efficiency.

The Co-Occurring Joint Action Council (COJAC) Funding Subcommittee is another example of efforts to increase opportunities to strategically plan for ways to combine funding for COD services. Recently, the subcommittee released a COD services funding matrix that outlines all of the possibilities for potential funding, including, but not limited to, Medi-Cal, GF

categorical programs, federal funds including Access to Recovery (ATR), and Minor Consent state-only Medi-Cal funding, etc.

Likewise, DMH and ADP continue to seek ways to untangle funding pathways to integrated services so that counties and providers have an easier time "braiding" fund sources for integrated treatment. This is an extremely difficult task, as California has a complex array of funding streams that come with specific requirements and little flexibility. This is a result of varied policy choices and overlaying State legislative and federal priorities that have evolved over time.

Going forward, ADP and DMH will continue to look for ways to combine funds where it is allowed. Certainly, the planned integration of behavioral health with primary care under health care reform presents promising options.

BACKGROUND

The California Department of Alcohol and Drug Programs (ADP) is one of twelve departments and one board under the California Health and Human Services Agency (CHHS), which is a cabinet-level agency that reports to the Governor.

ADP is designated as the Single State Agency (SSA) responsible for administering and coordinating the State's efforts in prevention, treatment, and recovery services for substance use disorder (SUD) services and problem gambling. ADP is also the primary state agency responsible for interagency coordination of these services. The mission of ADP is to lead efforts to reduce alcoholism, drug addiction, and problem gambling in California by developing, administering, and supporting prevention and treatment programs. The strategic vision of ADP is to have Californians understand that alcoholism, drug addiction, and problem gambling are chronic conditions that can be successfully prevented and treated.

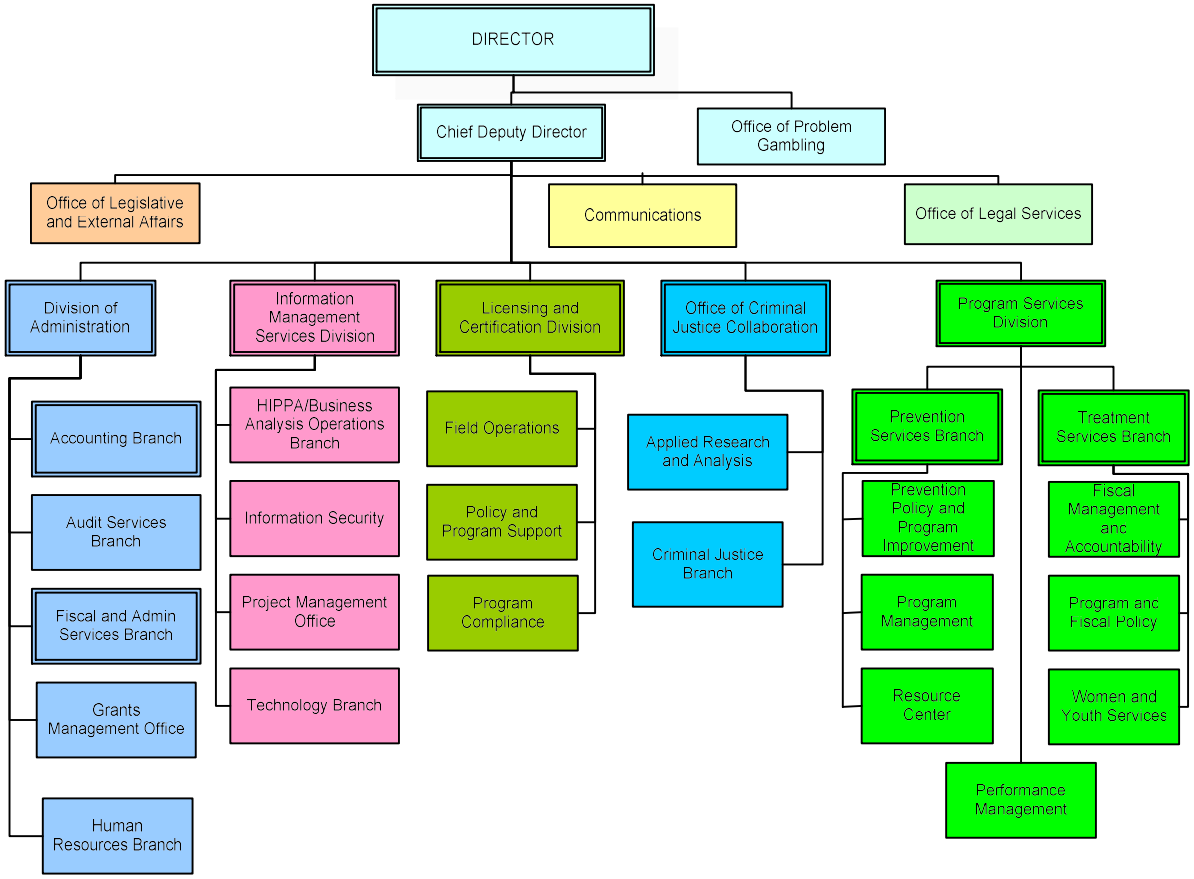
Following are the core functions and essential services of ADP:

- Administers Substance Abuse Prevention and Treatment (SAPT) Block Grant;
- Conducts Statewide Needs Assessment and Planning (SNAP);
- Administers the Drug Medi-Cal Program (DMC);
- Licenses and Certifies SUD Treatment Programs and Facilities;
- Licenses Narcotic Treatment Programs (NTPs);
- Ensures Statewide Access to Services;
- Assures Accountability through County Monitoring;
- Assures Accountability through Program Monitoring and Audits;
- Certifies SUD Counselors;
- Collects, Analyzes and Disseminates Information on County, Program, and Client Outcomes;
- Conducts Population Level Prevention Initiatives;
- Conducts Statewide Public Education Campaigns;
- Coordinates with Other Systems, Agencies and Departments to Address Related Issues and Problems;

- Determines the Balance between Uniformity and Innovation to Ensure Access to Quality and Effective Services;
- Establishes Competencies for Prevention and Treatment Personnel
- Establishes Standards for Program Services;
- Measures and Manages County and Program Performance;
- Provides a Statewide SUD Resource Center; and
- Provides Technical Assistance (TA) and Training to Improve the Use of the Strategic Planning Framework (SPF) and Expand the Use of Evidence-Based Practices

The ADP Director and Chief Deputy Director are appointed by the Governor of California. ADP is organized into the following five offices and four divisions: Office of Problem Gambling; Office of Legal Services; Office of Legislative and External Affairs; Office of Criminal Justice Collaboration; Communications; Program Services Division; Licensing and Certification Division; Division of Administration; and Information Management Services Division. ADP does not have a legislatively mandated advisory board; however, several statewide organizations provide valuable input to the Department on a regular basis. The organizational chart below shows ADP's structure as of June 2011.

Department of Alcohol and Drug Programs



Changing Landscape for Publicly-Funded Substance Use Disorder Services

California's publicly-funded system of SUD services has been evolving over the last several years to align practice more closely with scientifically derived models of effectiveness. Just as the federal government is moving towards a more accountable and effective system of SUD services, ADP has begun implementation of three efforts which are moving the department in the same direction: (1) building the capacity of the publicly-funded SUD services system as a chronic care model through the Continuum of Services System Re-engineering (COSSR) effort; (2) establishing an ongoing SNAP process in departmental operations; and 3) developing a framework for performance management at the State and local levels.

Continuum of Services System Re-engineering (COSSR)

COSSR is a systems change effort to evolve the publicly-funded continuum of SUD services system from an acute care system to one based on a chronic disease model. This change acknowledges that substance use causes problems of a continuous, chronic, and relapsing nature to both individuals and communities, necessitating continuing care and support.

Viewing substance dependence and addiction as a chronic disease has required a shift in thinking from the approach that currently informs SUD systems. A new, integrated system of care is necessary in order to achieve desired outcomes for the prevention, treatment, and recovery of those individuals and communities served by the SUD field. This new system of care requires integration and coordination from the many stakeholders in the SUD field who work in prevention, treatment, and recovery support services, as well as partners in mental health, primary health care, law enforcement, social services, and education.

The move toward this chronic disease model is expected to increase effectiveness of the system, as well as better position the system for integration with primary care. This department-wide change effort drives all programmatic activities and the administrative functions that support programming.

State Needs Assessment and Plan (SNAP)

SNAP informs COSSR efforts through the establishment of data-informed priorities and subsequent planning and implementation activities. SNAP is also an integral component in the process to determine departmental goals related to diversity and cultural competency needs as reflected in the Department's Cultural Competency Quality Improvement (CCQI) Strategic Plan, which will be further discussed later in this document.

The Needs Assessment is the first step in the SNAP process (assessment, planning, capacity building, implementation and evaluation). Central to this step is the establishment of an integrated substance use data monitoring, or surveillance, system to identify, evaluate, organize, and prioritize data sources and to track and analyze selected data indicators over time. This surveillance system will provide the SNAP process with the ongoing assessment data needed for data-informed planning, implementation and evaluation. This capacity building effort is currently underway through the grant-funded State Epidemiological Workgroup (SEW) project.

Performance Management

Performance management efforts started in 2007 between ADP, academic researchers at the University of California, Los Angeles—Integrated Substance Abuse Programs (UCLA-ISAP), and county SUD Administrator. This has produced positive results in collecting better data, increasing knowledge and use of performance measurement practices, and identifying gaps in the current system to move towards a performance model.

Significant strides have been made using the California Outcome Measurement System (CalOMS) Treatment and Prevention databases to collect more timely, accurate, complete and useful data. The State and counties are working collaboratively to improve data reporting quality and completeness through web-based tools and training, onsite training, and help-desk TA. These efforts require ongoing diligence in monitoring, workforce training, and data evaluation on the part of numerous staff at the provider, county, and State levels. Many counties have begun to use the data in both CalOMS systems to evaluate service provider performance, identify those in need of TA and training, as well as examine the practices of high performers in order to share greater system improvements. Within the Prevention system, counties have been required to link specific objectives from their SPF plans to each provider's contract and budget. This can improve the effectiveness of county oversight of specific performance goals and outcomes versus cost. Additionally, counties can monitor client treatment outcomes by provider and compare to countywide, or even statewide, outcomes within the treatment database to determine performance levels.

As ADP implements the continuum of care as envisioned by COSSR and as performance measurement and management practices evolve within the SUD field, ADP will be further modifying its data systems to ensure the data captured is useful for improving the quality of care, providing effective performance information for decision-makers, and demonstrating to the public the efficacy of SUD services.

These three change efforts provide a foundation upon which the State can build a more highly effective and adaptable service system. COSSR provides ADP with a broad conceptual framework that covers the full continuum of services from prevention and treatment to recovery support. The SNAP process is integrating the SPF planning process into all departmental activities and creating an ongoing data tracking system to provide timely and useful data and analyses for ADP decision makers. Efforts to improve performance management and measurement practices will be strengthened by the articulation of ADP institutional goals and outcomes, and the establishment of a monitoring system to provide the information necessary to measure progress toward these outcomes. Together these efforts better allow ADP to focus limited resources on efforts deemed the highest priority for California's publicly-funded system of SUD prevention, early intervention, treatment, and recovery support services.

State-County Partnership

SUD prevention, early intervention, treatment, and recovery services are provided to clients through a partnership between the State and counties, which are the sub-state planning areas. ADP contracts with counties for SUD services to be provided by locally administered and locally controlled substance use programs.

ADP staffers meet or confer weekly with members of the County Alcohol and Drug Program Administrators Association of California (CADPAAC), a statewide organization whose members represent California's 58 counties. In partnership with CADPAAC and in cooperation with numerous private and public agencies, organizations and individuals, ADP provides leadership and coordination in the planning, capacity building, development, implementation and evaluation of a comprehensive statewide SUD prevention, treatment and recovery system. The Department uses each of the 57 county alcohol and drug programs as brokers of service, and the counties in turn provide services to clients directly or by contracting with local service providers. ADP ensures compliance with federal requirements through periodic county monitoring visits.

The sub-state planning areas, which are the individual counties, are displayed below. One exception is Sutter and Yuba counties, which jointly administer SUD services.

Addressing the Diverse Needs of Californians by Ensuring Culturally Competent Services

Due to California's cultural and geographic diversity, the State-County Partnership is premised on the belief that SUD services provided at the community level help ensure equal access to all persons. These include individuals, who because of differences in language, cultural traditions, or physical disabilities, confront barriers to knowing about or accessing SUD services. ADP's Program Services Division (PSD) is charged with ensuring that the needs of special populations are met. PSD's organizational structure reflects ADP's

dedication to the underserved special populations within California. Within PSD, a special unit—the Women and Youth Services Branch—was established to address the needs of women and youth services, as well as veterans and individuals with co-occurring disorders (COD) in a culturally competent manner. PSD, along with the provision of TA to counties and providers through the new Culturally and Linguistically Appropriate Services (CLAS) initiative (further discussed below), support the SNAP process by ensuring that the SUD service system is culturally competent.

Prior to this effort, however, ADP held a long-standing commitment toward meeting the needs of California's culturally and linguistically rich population, through a multi-year commitment with its TA contracts designed to serve populations that suffer disparities in health care with providers that specialize in serving special populations. TA efforts focused on increasing access to services by addressing the unique needs of California's diverse population, including racial and ethnic minorities, the Lesbian, Gay, Bisexual, and Transgender (LGBT) community, and persons with disabilities. This long-standing commitment demonstrates ADP's commitment to ensuring California implements a culturally and linguistically competent prevention, treatment and recovery continuum of care.

Culturally and Linguistically Appropriate Services (CLAS)

As previously mentioned, ADP has also developed a CCQI Strategic Plan for 2010-12, which incorporated into ADP's business and operational practices the CLAS standards developed by the Office of Minority Health, U.S. Department of Health and Human Services. To ensure that CLAS standards are effectively implemented in the field, ADP has also launched the Community Alliance for CLAS, a multi-year effort that will ensure the SUD service system is culturally competent by achieving the following:

- Assessing Agency Readiness
  - Assess the readiness of SUD agencies to provide services under a CLAS delivery model. The assessments will guide training so that it is tailored to the assessed organizations' needs, functional activities of the workforce, and the needs of the population they serve.

- Training and TA
  - Provide a combination of comprehensive cultural competence training and TA. For example, some training will present a broad overview of CLAS to organizations that are receiving an introduction to CLAS standards. Other training will be specific to organizational plans based on assessed training needs. It will include workforce training on the cultural competence necessary to ensure the best client outcomes for communities with specialized characteristics, such as gender, ethnicity, veteran status, LGBT and Intersex status, as well as other target populations.

- CLAS Guidelines Development
  - Develop and disseminate CLAS guidelines that identify and document evidence-based and best practice models for cultural and linguistic competency for SUD agencies. The guidelines are intended to improve standardization across the

SUD treatment and recovery field, which will greatly influence client/consumer satisfaction. Guidelines will also serve as a foundation to start the policy discussion on the development of potential SUD CLAS regulations for the State of California.

- Marketing
  - Develop and implement statewide marketing strategies to inform the SUD treatment and recovery field of the availability of CLAS TA and training services to assure statewide access and service.

- Research/Clearinghouse
  - Serve as a clearinghouse for research and resources on evidence-based and promising practice models in cultural competence related to the provision of SUD services and improving client outcomes.

- Performance Evaluation
  - Continuously evaluate performance in meeting the overall contract goal of improving CLAS and client outcomes among SUD agencies. This includes distributing an evaluation form to all individuals/entities receiving services; following up with recipients of training and/or TA to assess the quality of services provided and ensure desired outcomes were achieved; developing and implementing a performance measurement process that identifies opportunities for continuous improvement; and developing and implementing an evaluation component that measures process and client outcomes among service recipients to determine the effectiveness of assessment and training and TA efforts.

SAMHSA Behavioral Health Policy Summit to Address Disparities within Healthcare Reform

California has continually sought opportunities to participate in national and statewide policy initiatives designed to address the needs of special populations. Such efforts have resulted in California being selected as one of the seven states chosen by SAMHSA to participate in its National Policy Summit to Address Behavioral Health Disparities within Health Care Reform. California places such a high value on the information garnered from such learning collaboratives that even during these difficult economic times of limited staff resources, it remains a policy imperative to continue with such endeavors.

The National Policy Summit was designed to assist states and territories with the development and implementation of public policies that will contribute to the elimination of behavioral health disparities within health care reform. The Summit planned to accomplish the following:

- Further states' understanding of the ACA as it relates to health disparities;

- Provide TA and expert consultation regarding implementation of particular policy issues identified as priority relative to the ACA; and

- Offer designated time and expert facilitation to assist states in developing a strategic plan with specific action steps to address policy and program changes necessary to eliminate disparities in behavioral health care

California's delegation consisted of 22 delegates from state, county and community-based mental health and SUD agencies. During the National Policy Summit, California's delegates worked together to develop a Strategic Action Plan that outlines collaborative efforts aimed at reducing behavioral health disparities within the state. Presently, a detailed Strategic Action Plan is being finalized by ADP and DMH, but will focus on three areas of priority:

- Strategic Implementation of the ACA
  - Engage community and county representatives in efforts that support advancement of California's 1115 waiver
  - Employ culturally proficient/appropriate approaches, increase public awareness of the opportunities that are, or will become, available through the ACA, and
  - Support behavioral health workforce development/enhancement

- Integration of Behavioral Health and Primary Care Services
  - Support the establishment of the Person-Centered Health Home and
  - Engage key stakeholders within the health care field in discussions which will help to ensure that behavioral health is a priority/key consideration when designing the new infrastructure for healthcare

- Prevention and Wellness
  - Increase community involvement in prevention and wellness efforts
  - Identify and support culturally appropriate prevention activities

Overall, California's participation in the National Policy Summit positions the State in getting a start on what will be required to reduce health disparities as the ACA's expansion of insurance coverage in 2014 greatly increases access to mental health and SUD services. Specifically, ADP looks forward to the following:

- Establishing partnerships/relationships with many important stakeholders within the behavioral health (and managed care) fields

- Laying the foundation for a plan which offers great opportunities to prepare the State to reduce behavioral health disparities by executing activities in the areas of community engagement, increased engagement of key stakeholders (State Insurance Commissioner, State agency leads, the Governor's Office, etc.), and the identification of existing resources (both in terms of culturally appropriate materials and existing federal funding) that can support workforce development (capacity and skill building), public education, and prevention efforts.

CONTINUUM OF SERVICES SYSTEM

Several specific programs and services operate within the continuum of services (COS) system. Some programs fund distinct types of services for specific subpopulations or serve a limited geographic area, while others serve eligible statewide participants and clients. Services in the COS system are supported by multiple funding streams, including combinations of state, local, and federal funds. Sources range from the SAPT Block Grant, General Fund (GF), the State Medicaid (Medi-Cal) program, and special grants from SAMHSA.

The following components form the California COS system for SUD prevention, early intervention, treatment, and recovery:

1. SAPT Block Grant Primary Prevention Set-Aside Services
2. SAPT Block Grant Treatment Services
3. GF Treatment Services
4. DMC (Medicaid)
5. Women and Youth Services
6. California Access to Recovery Effort (CARE)
7. Services for Criminal Justice Populations
8. Local Funding from Various Sources

California's existing COS system begins with primary prevention services. The continuum also includes intervention and client-centered, culturally appropriate treatment and recovery services. Prevention, treatment and recovery approaches should be based on an individual's and communities needs, preferences, experiences, and cultural backgrounds.

PREVENTION SERVICES

The mission of the PSD Prevention Services Branch (PSB) is to develop and maintain a comprehensive statewide prevention system to prevent and reduce SUD problems and to improve the health and safety of the citizens of California by:

- Modifying social and economic norms, conditions, and adverse consequences resulting from alcohol, tobacco, and other drug availability, manufacturing, distribution, promotion, sales, and use; and,
- Effectively addressing at-risk and underserved populations and their environments.

Primary prevention serves populations at three levels of risk: 1) Universal, for the general public; 2) Selective, for sub-populations at higher than average risk for substance use; and 3) Indicated, for those already using alcohol or other drugs or engaging in other high-risk behaviors, but not yet defined as in need of treatment. Approximately four million persons receive primary prevention services annually. These services include the following populations: youth/minors (elementary, middle school, high school), parents/families, military including youth in military families, economically disadvantaged individuals, college students, adults/older adults, persons using substances, delinquent/violent youth, women & children, children of substance abusers, foster youth, youth in the juvenile justice system,

tribal youth, and the LGBT population. The populations are those determined to be most in need by each county, through their SPF planning process.

Strategic Prevention Framework (SPF)

Over the years, research has shown that prevention services are most effective when they are evidence-based, data-informed, and outcome-oriented. ADP has been working to apply these principles in our business practices and to facilitate their implementation at the local level. As resources diminish, following the SPF model in collecting data will become increasingly important, making counties more competitive for other available funding as they become data informed, build local coalitions, and implement evidence-based prevention. Prevention data is collected according to the SPF framework.

In order to begin the process of meeting the Center for Substance Abuse Prevention's (CSAP) requirements to incorporate the SPF into statewide prevention efforts, in 2007 ADP required the counties to conduct a local needs assessment to identify populations/communities at greatest risk. Based on the outcomes of their needs assessment, the Net Negotiated Amount contract required counties to develop a strategic prevention plan to address their priorities. Given the new approach to planning, many counties needed assistance to obtain the data necessary to conduct a thorough needs assessment. ADP assists counties by:

1. Providing counties with the results of the State Epidemiology Workgroup (SEW);
2. Providing counties with local data through updated versions of the Indicators of Alcohol and Other Drug Risk and Consequences for California Counties;
3. Supporting continued funding of the California Healthy Kids Survey, and the California Student Survey (CSS).
4. Providing counties with TA; and
5. Making available the SEW to assist ADP's Prevention Services Branch in identifying and obtaining statewide data

ADP has been collaborating with CADPAAC through the CADPAAC Prevention Outcomes Workgroup to identify statewide prevention priorities that address populations and/or communities, both locally and statewide, with the greatest risk factors, and to develop outcomes, both locally and statewide, that measure prevention effectiveness.

Center for Substance Abuse Prevention (CSAP) Strategies

The majority of the SAPT Block Grant Primary Prevention Set-Aside is allocated to counties to engage in the six CSAP strategies and their related activities to meet goals and objectives determined through their SPF-based planning.

1. <u>Information Dissemination</u>

The counties provide information dissemination services according to their SPF-based planning. At the state level, the ADP Resource Center (RC) disseminates information, free-of-charge, throughout California. Examples include publications (select

publications available in other languages), a toll-free information and referral line, and loaning of SUD-related books and videos.

2. Education

The counties provide education services according to their SPF-based planning. Examples of evidence-based educational services provided are Project Alert, Project Success and Too Good for Drugs. At the state level, ADP conducts outreach and training to support youth, communities, and special service populations through TA contractors. As well, the RC maintains a portion of ADP's Internet Website to provide current TA documents, some curricula, and educational publications (see http://www.adp.ca.gov/RC/rc_sub.shtml).

3. Alternatives

The counties provide alternative services according to their SPF-based planning. It includes youth development activities that engage youth in planning and leading community prevention actions. The largest statewide program engaging in Alternative activities is the Friday Night Live (FNL) program (FNL-high school, Club Live-middle school, FNL Kids-elementary school) (see http://www.fridaynightlive.org/About/About.htm). The FNL system, based on a youth development framework, builds partnerships throughout the state for positive, healthy youth development by engaging young people as active leaders in their communities. The FNL system serves youth from all backgrounds, cultures, and demographics. FNL leadership is active in GPAC workgroups focused on high-rate substance and underage alcohol use. FNL programs across the State work closely with the California Highway Patrol and the Office of Traffic Safety to help young people buckle-up, slow down, prevent underage drinking and driving-while-under-the-influence.

4. Problem Identification and Referral

The counties provide problem identification and referral services according to their SPF-based planning. One California county developed the Individual Prevention Service (IPS) program based on the Brief Risk Review Interview and Intervention Model. Using the IPS, individuals are screened for SUD issues, and, if determined necessary, referred for a treatment assessment or more in-depth prevention education. At a statewide level through a GPAC workgroup focused on high-rate underage users, ADP, the California Department of Education (CDE), the Office of the Attorney General (AG) and other GPAC members will promote student assistance programs for the 1,000 school districts in California.

5. Community-Based Process

The counties provide community-based process services as part of their SPF-based planning (for example, accessing services, assessing needs and resources, and multi-agency collaboration). ADP provides TA services for local initiatives identified by community groups, prevention service providers, schools, neighborhood associations, and county administrators. This strategy will be supported by statewide TA and RC services to reach large population segments at an economical cost. The Community Prevention Initiative

(CPI) TA service provides extensive, immediate access to quality resources (see http://www.ca-cpi.org/Publications/publications_main_page.htm).

6. Environmental

The counties provide environmental services according to their SPF-based planning. Examples include social host ordinances, RBS training, alcohol availability and accessibility policies, identifying and changing harmful social norms regarding substance use. Statewide, ADP TA contractors develop, promote, and provide services on environmental prevention techniques for cities, emphasizing their local zoning authority and public policy development. As with the community-based strategy, the environmental strategy is strongly supported because it can reach larger population segments and use public policy to sustain effects.

State-Level Prevention Efforts

To support the delivery of prevention services at the local level, PSB performs the following activities at the State level:

- Staffing and coordination of the Governor's Prevention Advisory Council (GPAC), which coordinates the State's strategic efforts to address substance use issues;
- Interagency collaboration and coordination with other state departments on prevention issues to ensure substance use problems are appropriately addressed;
- Administer services through discretionary grants;
- Statewide implementation of the SPF to facilitate effective program planning. PSB works with counties to develop county prevention plans that are data informed, outcome driven and evidence based;
- Manage CalOMS Prevention which collects primary prevention data from SUD prevention providers throughout California to assure accountability for federal primary prevention funding and meet the federal National Outcome Measures;
- Tobacco Sales to Minors (the Synar Amendment), which requires states to pass and enforce laws that prohibit the sale of tobacco to individuals under 18 years of age and maintain a retailer violations rate that is at or below 20 percent;
- Research and analyze emerging issues (for example, evidence-based programming, binge drinking, marijuana legalization) to guide policy development;
- Provide TA and training to counties and service providers regarding strategic planning, data analysis, evaluation, evidence-based practices, and cultural and linguistic relevancy;
- Workforce development to increase capacity of the prevention field through the development and implementation of prevention core competencies; and
- Collaborate across systems to prepare the prevention field for opportunities related to health reform.

In addition to the SPF framework and the six CSAP strategies, the following program components support the delivery of primary prevention services:

Governor's Prevention Advisory Council (GPAC)

As a means of working across California's multiple state systems, ADP's Director chairs the GPAC which coordinates efforts to achieve measurable reductions in the incidence and prevalence of inappropriate use of alcohol, tobacco, and other drugs. Work with 16 agencies provides historical perspectives needed to attain long-term, sustainable results. GPAC has focused on finding common goals members can work toward through their agencies and affiliates. Workgroups are established for: (1) Screening, Brief Intervention and Referral and Treatment (SBIRT); (2) Underage Drinking, which addressed the problem of alcoholic energy drinks, held town hall meetings, and produced ADP web content; (3) evidence-based practices as they apply to different agencies; and (4) the SPF State Incentive Grant (SIG); and (5) SEW, seeking participation of other GPAC members that have substance use data that can inform GPAC and ADP.

Discretionary Grants

In the past, ADP has been awarded federal discretionary grants to further State prevention efforts. ADP's State Incentive Grant (SIG) focused on environmental prevention programs, strategies and policies. Social host ordinances created through this grant program have been used by other states to draft their legislation.

ADP used the Safe and Drug Free Schools and Communities State Grant, Governor's Program, to increase services to selective and indicated populations through a county grant program. Services focused specifically on youth in foster care, high rate/binge drinking youth, and youth with parents in treatment. In addition to evaluating individual county program efforts, a peer-led cross-site evaluation of the Governor's Program was instituted. The evaluation process, along with other learnings from these grant programs will be incorporated into any future discretionary grants received.

The SPF SIG will pilot a streamlined planning process that moves communities through the planning process, to implementation of evidence-based strategies, to outcomes. The SPF SIG workgroup will provide a mechanism to support identification of evidence-based policies, programs, and practices (EBPs) that are culturally relevant at the community level. The workgroup will assess sub-recipient strategic plans and logic models to determine the likelihood of success, given appropriateness of the strategy, proposed program adaptations, and cultural considerations. This will lay the groundwork for implementation of the SPF and use of EBPs on a statewide level.

EARLY INTERVENTION SERVICES

Early intervention services (EIS) include brief intervention and referral to treatment. EIS are designed to come between a substance user and his or her actions in order to modify behavior. They include a wide spectrum of activities ranging from user education to formal intervention and referral to appropriate treatment/recovery services. For example, transient or non-dependent alcohol or other substance use problems can often be resolved through acute care, including brief intervention and brief treatment services.

ADP plans to build upon existing infrastructure and the existing expertise developed over a number of years administering a SAMHSA SBIRT Grant to implement goals relating to early intervention services identified in SNAP (State Priority 2). ADP will seek to develop linkages between primary care and specialty SUD providers and utilize incentives as a means to encourage treatment referrals from primary to specialty care. Implementation will begin by utilizing the knowledge gained in developing SBIRT services to diverse populations in Los Angeles and San Diego counties by using those counties' SBIRT staff and practioners to develop statewide protocols and standards for SBIRT practices. In San Diego, SBIRT services addressed alcohol and other substance use, targeted adults and older adults, and were managed and provided in multiple healthcare settings, including federally qualified health centers (FQHCs), emergency departments, and trauma centers. In Los Angeles, services targeted short-term jail detainees (in custody between 72-96 hours) for substance use risk factors upon their release from custody and referred to treatment those needing more extensive services.

Once protocols have been developed, ADP plans to utilize its State Medical Director for SUD Services and staff from the Pacific Southwest Addiction Technology Transfer Center to provide SBIRT training to physicians employed by FQHCs and county-operated health clinics. One option currently under consideration is that ADP would seek SAMHSA's permission to authorize ADP's county partners to use SAPT Block Grant funds to reimburse county health clinics and community clinics, comprised primarily of FQHCs, for each referral from a health clinic to the county's specialized SUD treatment services. Referrals would be reimbursed when a clinic patient that has been screened for substance use is referred and presents oneself for treatment at a county alcohol and drug program office after the screener has determined the patient is in need of SUD treatment.

TREATMENT SERVICES

While each funding stream has its respective regulations and requirements, there is general conformity among the various treatment modalities and services, regardless of the funding source.

Across the existing COS system, there are several treatment modalities and services:

Assessment, Referrals, and Intake

The intake process begins with assessing the individual's needs to assure that clients are placed in the most appropriate treatment modality and are provided with a continuum of services that will adequately support recovery.

Case Management

Case Management services are activities involved in the integration and coordination of all necessary services to ensure successful treatment and recovery. Services may include outreach, intake, assessment, individual service plans, monitoring and evaluation of progress, and community resource referrals.

Nonresidential Treatment

Nonresidential treatment services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, and resource information about health, social, vocational, and other community services, with assistance to some clients in obtaining services. These services are available to youth, ages 12 to 17, and adults. In addition, perinatal providers must provide gender-specific services tailored to meet the treatment, therapeutic, and recovery needs of women and their children. Perinatal providers must also make primary medical care available to the women and their children.

Rehabilitative Ambulatory Intensive Outpatient (Day Care Rehabilitative)
Day Care Rehabilitative (DCR) services are intensive outpatient counseling and rehabilitative services that typically last a minimum of 3 hours but are less than 24 hours per day for three or more days per week. DCR differs from non-intensive Rehabilitative/Ambulatory Outpatient services, in which clients participate according to a minimum attendance schedule and receive regularly assigned treatment activities.

Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free - Group
Treatment/recovery or rehabilitation services are provided to a client who does not reside in a treatment facility. The client receives SUD treatment services with or without medication, including counseling and/or supportive services.

Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free - Individual
Treatment/recovery or rehabilitation services are provided to a client who does not reside in a treatment facility. The client receives SUD treatment services with or without medication, including counseling and/or supportive services.

Outpatient Methadone Detoxification (OMD)
This service provides narcotic withdrawal treatment pursuant to the California Code of Regulations (CCR) Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification treatment for reporting purposes.

Inpatient Methadone Detoxification (IMD)
In a controlled, 24-hour hospital setting, this service element provides narcotic withdrawal treatment pursuant to CCR Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification treatment for reporting purposes.

Rehabilitative Ambulatory Detoxification (Other than Methadone)
Rehabilitative ambulatory detoxification is an outpatient treatment service rendered in less than 24 hours; it provides for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

Narcotic Replacement Therapy

Narcotic Treatment Programs (NTPs) provide narcotic replacement therapy using methadone, buprenorphine and any other Federal Drug Administration (FDA)-approved medications for the treatment of opioid addiction. Medication is dispensed on-site in specialized clinics, as required by federal law. In addition to federal requirements, California also currently regulates the use of methadone. Federal statute allows buprenorphine to be prescribed by a physician in office-based practice who has obtained a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver. California does not independently regulate the use of this medication and refers to the federal Center for Substance Abuse Treatment (CSAT) guidelines. Narcotic replacement therapy also includes assessment, treatment planning, urinalysis drug testing, group and individual counseling, and educational sessions.

Residential Treatment

ADP must license all non-medical adult residential facilities that provide alcohol and drug treatment services on-site. Residential Adolescent Group Homes are licensed by the California Department of Social Services. Residential services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, detoxification services, and information about, and may include assistance in obtaining, health, social, vocational, and other community services. These services are available to youth, ages 12 to 17, and adults. In addition, perinatal providers must provide gender specific services tailored to meet the treatment, therapeutic, and recovery needs of women and their children. Perinatal providers must also make primary medical care available to the women and their children.

Free-Standing Residential Detoxification

Free-standing residential detoxification provides detoxification services in a non-hospital setting, which is designed to provide for safe withdrawal and transition to ongoing treatment.

Residential/Recovery Long Term (over 30 days)

Long-term residential care is typically more than 30 days of nonacute care in a setting with recovery/treatment services for substance use and dependency.

Residential/Recovery Short Term (up to 30 days)

Short-term residential care is typically 30 days or less of nonacute care in a setting with recovery/treatment services for alcohol and other drug abuse and dependency.

Other Services

The following services are part of the outreach, engagement, and treatment support services. They are an important part of the treatment continuum, and therefore are included here.

Outreach

Outreach activities are designed to identify and encourage eligible individuals with SUD to obtain treatment services, including intravenous drug users and pregnant and parenting women. Outreach may also be used to educate the professional community on perinatal services so that they become referral sources for potential clients.

Following are the previously mentioned components of the COS:

SAPT Block Grant TREATMENT SERVICES

The SAPT Block Grant is an essential source of support for the COS in California. The SAPT Block Grant provides significant support for SUD treatment, prevention, and recovery services for the general population. California has also used its SAPT Block Grant award to categorically fund services for specific populations. These earmarked SAPT Block Grant funds support the criminal justice-related Female Offender Treatment Program (FOTP) for women released from custody with the goal of facilitating their reentry into society. Other earmarked SAPT Block Grant funds support Women and Youth Services (perinatal programs for pregnant/parenting women and adolescent treatment programs). Counties can also opt to use SAPT Block Grant funds to augment services for specific populations, such as youth and pregnant and parenting women.

GF TREATMENT SERVICES

GF is used to match the federal financial participation for DMC (Medicaid). GF is also used to fund non-SAPT, non-DMC programs and services, including:

- GF Ongoing: funds are available to counties to meet the cost of alcohol and other drug services;

- GF Perinatal Ongoing: funds are for programs that serve populations of pregnant and postpartum women and their infants, and parenting women and their children through 17 years of age; and

- Women and Children's Residential Treatment Services: these funds are allocated to continue funding eight existing perinatal treatment programs that were created with grants (since expired) from the federal Center for Substance Abuse Treatment.

DMC TREATMENT SERVICES

As part of the State Medicaid program, DMC provides *medically necessary* SUD treatment to California's Medicaid-eligible population statewide. DMC services include Outpatient Drug Free individual and group counseling, Narcotic Treatment, and Naltrexone Treatment. These are available to *all* eligible low-income people needing SUD treatment but lacking health insurance. This group also includes uninsured families and individuals whose incomes are too high to qualify for cash assistance but who otherwise qualify for California Work Opportunity and Responsibility to Kids (CalWORKs) or for Supplemental Security Income/State Supplementary Payment (SSI/SSP). Perinatal Residential SUD services are

available only to pregnant and postpartum women with SUD diagnoses. Day Care Rehabilitative services are available to both pregnant and postpartum women and Early Periodic Screening Diagnosis and Treatment (EPSDT)-eligible beneficiaries. In addition, EPSDT Supplemental Services are available to youth through the Department of Health Care Services (DHCS) Treatment Authorization Request (TAR) process.

All services below are provided by staff lawfully authorized to provide, prescribe, and/or order these services within the scope of their practice or licensure:

Outpatient Drug Free

Outpatient Drug Free (medication-free) services are provided when the client does not reside in a treatment facility. Services are directed at stabilizing and rehabilitating persons with SUD diagnoses and consist primarily of counseling services. Once a licensed physician determines medical necessity, the patient can be admitted to Outpatient Drug Free services. These services include: intake, admission physical examinations, medical direction, medication services, body specimens, treatment and discharge planning, crisis intervention, collateral services, and individual and group counseling.

Day Care Rehabilitative

Day care rehabilitative services provide outpatient counseling and rehabilitation services at least three hours per day for three days per week to persons with SUD diagnoses, who are pregnant or in the postpartum period, and/or are EPSDT-eligible beneficiaries. The range of services include: intake, admission physical examinations, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services and crisis intervention. Additionally, parenting education is available.

Naltrexone Treatment Services

This is an outpatient treatment service directed at serving detoxified clients with a SUD diagnosis of opiate dependence. Naltrexone is a medication that blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction. Naltrexone treatment services are provided only to individuals with a confirmed, documented history of opiate addiction and are at least 18 years of age; opiate free and not pregnant. The service regimen includes: intake, admission physical examination, treatment planning, medication services, individual counseling, group counseling, collateral services, and crisis intervention.

Perinatal Residential SUD Services

This category of DMC is a non-institutional, non-medical, residential program that provides rehabilitation services to pregnant and postpartum women with SUD diagnoses. Perinatal services address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills. Women reside in the treatment facility in order to support efforts to restore, maintain, and apply interpersonal and independent living skills, as well as access community support systems. General procedures include: intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention.

Services include the following:

- Mother/child habilitative and rehabilitative services
    - Development of parenting skills, training in child development, which may include child care
- Service access
    - Transportation to and from medically necessary treatment
- Parenting education
- Coordination of ancillary services
    - Assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant.

Narcotic Treatment Programs

Narcotic Treatment Programs (NTPs) provide narcotic replacement therapy (NRT) using methadone and other federally allowed medications as maintenance medication for detoxified clients with opioid dependence. Methadone is currently the only medication dispensed by NTPs that is reimbursable as a DMC benefit. (NTPs also serve some patients who are private payers.) Methadone is the most widely known and well-researched treatment for opioid dependency. The goals of therapy are to prevent abstinence syndrome (relapse), reduce narcotic cravings and block the euphoric effects of opiate use. Methadone is used as one component of a comprehensive treatment program for narcotic addiction, along with a medical evaluation, treatment planning, urinalysis drug testing, group and individual counseling, and educational sessions.

The maintenance phase of treatment provides replacement narcotic medication to patients in sustained, stable, and medically determined doses. The purpose is to reduce or eliminate chronic opiate addiction while the patient is provided a comprehensive range of additional treatment services. Methadone maintenance treatment is proven as a cost-effective alternative to incarceration or hospitalization. Once patients are maintained on a stable dose level, it is often possible to address their other chronic medical and psychiatric conditions.

Patients stay on methadone as long as medically necessary to reduce or eliminate the craving to use opiates. A medical decision to discontinue methadone should come directly from the treatment provider's staff physician after discussing options with the patient, as methadone maintenance is a necessary component of an effective treatment plan for the patient. Methadone should not be discontinued without the full cooperation of both the physician and the patient.

WOMEN AND YOUTH SERVICES

Women's and Perinatal Services

The Perinatal Services Network includes approximately 189 SAPT Block Grant-funded treatment and recovery programs designed specifically to provide services for pregnant and parenting women. In previous block grant applications, the number of perinatal programs included programs that received only DMC funds. Those programs were excluded in this

count because they are not required to comply with the SAPT Block Grant requirements for interim services and preferences.

Perinatal programs serve over 32,200 women annually. The target population includes pregnant and substance using; or parenting and substance using, with a child(ren) ages birth through 17. This parenting group also includes women attempting to regain legal custody of their child(ren).
Perinatal programs are designed to empower women to achieve and maintain clean and sober living, deliver healthy infants, strengthen family units and lead productive lives. Perinatal programs provide or arrange for gender-specific, culturally relevant, SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and other needed services.

The following treatment modalities and ancillary services are available to women: Outpatient Drug-Free; Daycare Rehabilitative; Narcotic Replacement Therapy; Outpatient Detoxification Treatment (Other than Narcotic Treatment Detoxification); Residential Treatment; Transitional Living Centers; Alcohol and Drug-Free Housing; and Aftercare.

Additional components include:

- Outreach
    - identifies eligible pregnant and parenting women who need treatment services and encourages them to take advantage of these services
- Case management
    - facilitates access to primary medical care, primary pediatric care, and gender specific SUD recovery and treatment, and other needed services
- Transportation
- Child Care
    - on-site or through a licensed or licensure-exempt cooperative
- Education
    - educational/vocational training and life skills resources;
    - TB and HIV education and counseling;
    - parenting education; and
    - parenting skills building and child development information.

Adolescent Treatment Programs (ATP)

SAPT Block Grant funds support comprehensive, age-appropriate, SUD services to youth. ADP currently oversees a statewide network of approximately 390 publicly funded SUD treatment programs that annually serve approximately 12,000 youth. The target population for youth treatment is individuals 12 through 17 years old (inclusive). The focus of services varies by county, depending upon local need and priorities.

ATP funds are allocated to counties to provide services such as:

- Outreach
- Early intervention
    - This level of care is delivered in a variety of settings and usually consists of brief contact or a series of contacts designed to explore and address problems

or risk factors that are related to substance use. It is most appropriate for youth with low SUD problem severity (experimental and regular use) and those who do not meet the diagnosis for a substance-related disorder

- Low intensive outpatient treatment
    - The level of care equivalent to Adolescent Level I in the American Society of Addiction Medicine Patient Placement Criteria-2nd Revision (ASAM PPC-2R). This level of care may be provided in any age-appropriate setting and is appropriate for youth with low to medium problem severity
- High intensive outpatient treatment" (or day treatment)
    - The level of care equivalent to Adolescent Level II in the ASAM PPC-2R. This level of care is usually provided in a school or community-based program. It extends the school day to include a wide array of services. It is appropriate for youth with severe problems related to their substance use, which could potentially distract the youth from their recovery efforts
- Residential treatment in group home settings and juvenile detention facilities.

Additional ATP services components include:

- Screening, Initial & Continuing Assessment
- Diagnosis, Placement, & Treatment Planning
- Counseling
- Youth Developmental Approaches to Treatment
- Family Interventions and Support Systems
- Educational and Vocational Activities
- Structured Recovery-Related Activities
- Alcohol and Drug Testing
- Discharge Planning.

CALIFORNIA ACCESS TO RECOVERY EFFORT (CARE)

The CARE program is the state's implementation of the federal Access to Recovery grant. Historically, California had limited resources for youth SUD services, so CARE initially focused exclusively on youth (12 to 20 year olds). In 2010, CARE expanded to also serve young military service members/veterans (through age 25) to help them access SUD services. CARE provides (virtual) vouchers for SUD services to eligible youth and service members/veterans who reside in one of five target counties (Butte, Los Angeles, Sacramento, Shasta, and Tehama). Once evaluated by an ADP-approved assessment provider (sites and mobile clinicians), clients are issued vouchers and can select their service provider(s) from a variety of ADP-approved organizations, including faith-based and grassroots organizations. CARE offers outpatient treatment and recovery support in a variety of settings.

Clinical services include: screening and assessment, case management, individual and group counseling, individual family therapy, education sessions, drug testing, and telephonic continuing care.

Recovery support services include: employment and educational services, therapeutic and structured recreation, peer coaching, spiritual coaching, and transportation.

CRIMINAL JUSTICE POPULATIONS

Parolee Services Network

These GF services provide residential and non-residential alcohol and other drug treatment and recovery services for men and women paroled to the community from State prisons. These services are available in the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Marin, Napa, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma. The benefits of the program include:

- Placement of parolees in appropriate alcohol and other drug treatment and recovery programs, either from the community parole systems or immediately upon release from prison custody;
- Improvement of parolee outcomes as evidenced by fewer drug-related revocations and related criminal violations;
- Support of parolee reintegration into society by encouraging a clean and sober lifestyle; and
- Reduced General Fund costs for incarceration and parole supervision.

Female Offender Treatment Program (FOTP)

This program receives SAPT Block Grant funding for residential and outpatient alcohol and drug treatment and recovery services to female parolees in four counties. The FOTP provides six months of community residential SUD treatment for paroled women who complete the Forever Free program at the California Institution for Women. The four participating counties are Los Angeles, Orange, Riverside, and San Bernardino. Other women on parole who didn't complete the Forever Free Program may participate on a case-by-case basis if the Female Offender Treatment Project underutilizes the funding.

Drug Court Programs

Drug Courts are supported by the GF, which provide funding to 53 of the 58 counties, totaling 133 drug courts. Drug courts are designed to reduce drug usage and recidivism, provide court supervised treatment, and offer the capability to integrate drug treatment with other rehabilitative services to promote long-term recovery and reduce social costs. Drug courts are diverse and serve varied populations of adults, parents of children in the Child Welfare System, juveniles, repeat drug offenders, multiple offenders, and drug-offending probation violators. Generally, drug court participants have misused alcohol and other drugs for ten years or more and received little or no SUD treatment.

Across the state, local agencies have developed adult, juvenile, and dependency drug courts, which generally fall into one of four models (pre-plea, post-plea, post-adjudication, and civil):

Adult Drug Courts

Adult Drug Courts focus on adult offenders who are convicted felons. The primary purpose of adult drug court is to provide access to treatment for substance-abusing offenders while minimizing the use of incarceration. This is achieved by providing a structure that links supervision and treatment with ongoing judicial oversight and team management. A majority of drug courts include initial intensive treatment services with ongoing monitoring and continuing care for 12 months or more.

Juvenile Drug Courts

Juvenile Drug Courts focus on delinquency matters that involve substance-using juveniles by providing immediate and intensive intervention with continuous court supervision. This includes requiring both the juvenile and the family to participate in treatment, submit to frequent drug testing, appear regularly at frequent court status hearings, and comply with other court conditions geared toward accountability, rehabilitation, long-term sobriety and cessation of criminal activity.

Dependency Drug Courts (DDC)

Dependency Drug Courts focus on cases involving parental rights in which an adult is the party litigant and there is a substance use charge against a parent. The goal is to provide parent(s) with the necessary parenting skills and treatment for their substance disorder in order to allow children to remain safely in their care and to help decrease the number of children placed in foster care.

Driving-Under-the-Influence (DUI) Programs

DUI programs aim to reduce the number of repeat DUI offenses by persons who complete a state-licensed DUI program and provide participants an opportunity to address problems related to the use of alcohol and/or other drugs. The county board of supervisors, in concert with the county alcohol and drug program administrators, determines the need for DUI program services and recommends applicants to the state for licensure. ADP licenses programs, establishes regulations, approves participant fees and fee schedules, and provides DUI information.

LOCAL FUNDING FROM OTHER SOURCES

Counties also contribute their own local funds to support SUD services.

RECOVERY SUPPORT SERVICES

Recovery support (aftercare) services (RSS) may begin during or following treatment services and involve coordination, relapse prevention, continuing comprehensive assessments, motivational counseling, recovery maintenance planning, and exit planning. Referrals to additional services such as family preservation and reunification, child care, housing (sober living, safe housing, permanent housing), drop-in services, transportation, peer support and mentoring, and education/life skills training are often provided.

Despite scant funding, counties within the state have long used Recovery Support Services to meet the needs of communities. RSS are funded using county discretionary funds, SAPTBG, California Mental Health Services Act funds, grants (e.g. State and/or SAMHSA grants), and through treatment providers.

California is in the early stages of building RSS within the COS by developing guidelines on RSS measurement and standardizing program performance and client outcome measures to test the efficacy of these services.

SPECIALIZED SERVICES

Specialized Services to Women and Women with Dependent Children

In accordance with 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e), ADP ensures that specialized services for pregnant women and women with dependent children will be provided through a county based system in California. These will be "operationalized" through the Negotiated Net Amount Contracts entered into between ADP and the counties. The NNA contracts will authorize the counties to spend funds in accordance with federal statutes, regulations, guidelines and State requirements. ADP will make annual funding allocations to the counties; these allocations will include a perinatal set-aside for each county. The counties, in turn, will provide the treatment services and/or will enter into agreements with local entities to provide perinatal services. ADP estimates that 15,258 pregnant and/or parenting women annually will receive specialized services described below.

The "perinatal set-aside" funds will be expended by service providers in accordance with the Perinatal Services Network Guidelines (2009), which will be incorporated by reference in the NNA contracts.

To be eligible for perinatal funding, a program must serve women who are either:

- pregnant and substance using; or
- parenting and substance using, with a child(ren) ages birth through 17. Parenting also includes a woman who is attempting to regain legal custody of her child(ren).

Programs must provide or arrange gender-specific substance abuse treatment and other therapeutic interventions for women who may address issues of relationships, sexual and physical abuse, and parenting.

Programs must provide or arrange sufficient case management to ensure that women and their children have access to primary medical care, primary pediatric care, gender-specific substance abuse recovery and treatment, and other needed services.

Transportation must be provided or arranged to and from the recovery and treatment site, and to and from ancillary services for women who do not have their own transportation.

Programs must provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

Child care must be available for program participant's children while the women are participating in on-site treatment program activities and off-site ancillary services. Depending on the age of the child, the following requirements apply:

1. Child care must be on-site for participant's children between birth and 36 months while the mothers are participating in the program (unless a waiver is approved by ADP).
2. Child care may be provided on-site or off-site for participants children who are between 37 months and 12 years of age.
3. Child care for children between 13 and 17 years of age, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children.

Programs must provide or arrange for the following services:

- educational/vocational training and life skills resources;
- TB and HIV education and counseling;
- education and information on the effects of alcohol and drug use during pregnancy and breast feeding; and
- parenting skills building and child development information.

Programs are required to provide or arrange primary medical care for women in treatment, including referrals for prenatal care. They also must provide or arrange primary pediatric care, including immunizations, for dependent children.

Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal SAPT Block Grant funds. Medi-Cal, Medicare, and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees providing the county approved schedule of fee assessment and collection is applied. General Funds cannot be used to provide medical treatment.

Counties must publicize that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them.

Counties are responsible for contracting with providers, ensuring that all perinatal programs meet their contractual requirements, and ensuring that quality perinatal services are provided. Staff from ADP's, Program Services Division, Licensing and Certification Division, and Audit Services Branch may conduct site visits to ensure compliance with the specific regulations monitored by each division.

The following SAPT Block Grant funded perinatal treatment modalities and services will be funded:

Outpatient Treatment
This modality provides alcohol and other drug (AOD) treatment services, with or without medication, in a non-residential setting. There is no minimum number of treatment hours prescribed.

Daycare Rehabilitative (DCR) Treatment
This modality provides AOD treatment services in a non-residential setting to each client for two or more hours, but less than 24 hours per day, for three or more days per week.

Narcotic Treatment Program (NTP)
This modality combines AOD treatment services with one of the following approved narcotic replacement drugs:

- *Methadone* treatment provides AOD treatment services in a non-residential facility along with methadone as prescribed by a physician to alleviate the symptoms of withdrawal from opiates (maintenance) or in decreasing amounts in a planned withdrawal from opiate dependence (detoxification).

- *LAAM* (levo-alpha-cetyl-methadol) treatment provides AOD treatment services in a non-residential facility, along with LAAM as prescribed by a physician to alleviate the symptoms of withdrawal from opiates.

Outpatient Detoxification Treatment (Other than Narcotic Treatment Detoxification)
This modality provides AOD treatment services, with or without medication, for safe withdrawal from alcohol or drugs in a non-residential, ambulatory setting for less than 24 hours per day.

Residential Treatment (Detoxification or Recovery)
This modality provides AOD treatment services in a residential, non-acute care setting.

Outreach
An element of service that identifies eligible pregnant and parenting women in need of treatment services and encourages them to take advantage of these services. Outreach may include engagement of prospective program participants by informing them of available treatment services, and can serve as “pre-treatment” by reinforcing prevention and education messages prior to enrollment in treatment. Outreach also may be used to educate the professional community on perinatal services so that they become referral sources for potential clients.

Interim Services
These are services provided to pregnant women or injection drug using women seeking substance abuse treatment who cannot be admitted to a program due to capacity limitations. Interim services are defined as:

- Counseling and education about human immunodeficiency virus (HIV) and tuberculosis (TB), the risk of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
- Referrals for HIV or TB treatment services, if necessary.

- Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.
- Referrals based on individual assessments that may include, but are not limited to: self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, children's services, medical services, and Temporary Assistance to Needy Families (TANF)/Medi-Cal services.

Case Management
A participant-centered, goal-oriented process for assessing the needs of an individual for particular services; assisting the participant in obtaining those services; and reviewing participant accomplishments, outcomes, and barriers to completing recovery modality or a free-standing service.

Aftercare
Aftercare provides structured services in an outpatient setting to individuals who have completed treatment to support the gradual transition of the individual back into the community, prevent relapse, and ensure successful recovery. Aftercare may be either an element of a recovery and treatment modality or a free-standing service.

In the base year, FFY 1994, the amount expended was $26,349,134. ADP is required to maintain this funding level, at a minimum.

Services to Intravenous Drug Abusers

In accordance with 42 U.S.C. §300x-23 and 45 C.F.R §96.126, ADP ensures that admission preferences, interim services, treatment, outreach, and capacity and waiting list reporting requirements for Intravenous Drug Users (IVDU), will be provided through a county based system in California. The services and requirements related to IVDU will be "operationalized" through the Negotiated Net Amount (NNA) contracts entered into between the Department of Alcohol and Drug Programs (ADP) and the counties. The counties may operate IVDU programs, or they may enter into agreements with local entities to operate the programs. ADP estimates that it will annually serve approximately 23,170 unique individuals who are injection drug users.

Programs and services for screening and intake of IVDU will include outpatient methadone maintenance; outpatient methadone detoxification; outpatient counseling treatment; residential detoxification; residential treatment; perinatal residential, outpatient, and day care rehabilitative services. Persons who use drugs intravenously and test positive for HIV will be referred to appropriate treatment and care. ADP will meet federal requirements for services to IVDU through the following activities:

90 Percent Capacity Reporting
All alcohol and other drug (AOD) treatment providers receiving State or federal funds or licensed by the State to dispense methadone will be required to submit data to the State's Capacity/Waiting List Management Program called the Drug and Alcohol Treatment Access Report (DATAR) system each month. ADP and the counties will use the data and reports to monitor capacity and utilization.

14-120 Day Performance Requirement

The monthly DATAR will contain specific information regarding the number of days IVDU applicants wait for admission to publicly-funded AOD programs. This information will be tabulated, and reports and information with aggregated data will be electronically available to County Alcohol and Drug Program Administrators for monitoring and planning.

To meet the Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements and improve the effectiveness of this system, ADP will post information on its website and collaborate with county alcohol and drug program administrators and direct providers. During the annual county compliance reviews, local procedures for maintaining contact with individuals awaiting admission and providing priority placement for IVDU and pregnant women will be examined.

Interim Services

ADP will require counties; through NNA contracts to ensure that federally mandated interim services to IVDUs awaiting admission to treatment programs are provided. These services will include:

- Counseling and education about HIV and TB, risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to mitigate risks of HIV and/or TB transmission.
- Referral for HIV and TB testing, and if necessary, treatment through arrangements with county health departments.
- For pregnant women, counseling on the effects of alcohol and other drug use on the fetus and referral for prenatal care.

Providers will be required to document compliance with requirements to provide interim services and priority placement for IVDU and pregnant women. Procedures for providing interim services for IVDU and pregnant women will be evaluated during ADP's annual county compliance reviews.

Outreach

The SAPT Block Grant requirement on encouraging individuals that need IVDU treatment services to obtain services are contained in the county NNA contracts. ADP will require counties to include federal requirements for outreach activities in all their contracts with providers. Counties are required to monitor compliance with this requirement and to take corrective action for noncompliance. Technical assistance and information will be made available to providers as needed.

ADP will collaborate with four counties to provide special outreach services through the California Institution for Women's prison-based Female Offender Treatment Program (FOTP). The FOTP will offer a continuum of community-based residential and outpatient, alcohol and other drug treatment and recovery services for up to six months to women, including IVDU, paroled from prison, who live in Los Angeles, Orange, Riverside, and San Bernardino Counties.

Monitoring

ADP's Performance Management Branch will perform annual compliance reviews of all county administrative systems to ensure compliance with SAPT funding requirements. ADP

will maintain DATAR. Publicly-funded programs will be required to report to DATAR. ADP plans to continue efforts to improve DATAR, including the following activities:

- Providing ongoing DATAR training and technical assistance (TA) by telephone and ADP's Web site to counties and direct providers to enhance accuracy and the rate of on-time reporting.
- Implementing new technologies to improve the quality of data transfer and processing, and
- Reducing the time required to accomplish these activities.

ADP will provide and maintain a user-friendly Web-based application that will allow providers to submit DATAR data over the Internet. The objectives of the system are to provide more efficient, effective, and comprehensive source of management information needed for strategic program monitoring and resource allocation. The Web-based DATAR will allow on-demand monitoring and utilization reports for providers, counties, and the State. It also supports a process for the systematic reporting of treatment demand and public treatment capacity utilization.

Collecting outcomes information facilitates the improvement of service delivery and as such remains key to ensuring continuous quality improvement. Along with DATAR, the California Outcomes Monitoring System–Treatment (CalOMS-Tx) will promote admission program compliance by asking how long an IVDU (or other) client waited for treatment admission.

Counties and direct providers will be required to collect CalOMS-Tx and DATAR data and submit this information electronically to ADP. Counties and direct providers will be the single source of CalOMS-Tx and DATAR data collection and will submit data at least monthly to ADP. However, data submission will not be limited to once per reporting month. For example, CalOMS-Tx and DATAR data files can be submitted hourly, daily, once a week, etc., during a given report month. Data submitted to ADP will update the CalOMS-Tx and DATAR databases and counties and direct providers will be able to extract their data and reports from these databases for evaluation and planning purposes.

CalOMS-Tx data reporting will involve collecting the required CalOMS-Tx data elements from every participant each time he/she is enrolled in AOD treatment services at a reporting facility. Each participant's initial admission to the facility and any subsequent transfers or changes in service will be reported in a separate CalOMS-Tx record. If a participant remains in treatment for one year or longer, CalOMS-Tx annual update data will be collected and reported. When a participant leaves treatment, CalOMS-Tx discharge data will be collected and submitted to ADP.

Data will be collected on all service recipients, by all providers that receive funding from ADP and at all licensed narcotic treatment programs, regardless of the source of funds used for the service recipient. For example, if a provider receives ADP funding, but provides services to a person using only county funds, or provides services to a private pay client, the provider will still collect and submit CalOMS-Tx data for that individual.

As part of ADP's priority of increasing the effectiveness of its publicly-funded treatment services, ADP will continue to survey and provide appropriate prevention and treatment

services for the IVDU population. ADP continues to collaborate with the California Department of Public Health's Office of AIDS as part of its continued effort to stay informed about factors that impact this population.

Tuberculosis (TB) Services

In accordance with 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127, ADP ensures that tuberculosis (TB) testing, treatment, and referral requirements will be met through a county-based system in California. Meeting these requirements will be "operationalized" through the Negotiated Net Amount Contracts entered into between ADP and the counties. The NNA contracts will authorize the counties to spend funds in accordance with federal statutes, regulations, guidelines and State requirements. Everyone receiving substance use disorder (SUD) treatment services in California must provide documented evidence of their TB status, and if positive, evidence of ongoing treatment or a physician's clearance to participate in an SUD treatment program. County alcohol and other drug (AOD) programs and providers will refer individuals needing SUD treatment and TB testing/treatment to local public health departments for specialized care. ADP estimates that the number of SUD treatment unique clients diagnosed with TB will be approximately 2,762 annually.

Prospective clients lacking documented evidence or a physician's clearance will be referred to an allied health facility for a skin test, where in most cases, results are immediately evaluated. Or, alternatively, the skin test will be administered at the SUD treatment facility and interpreted by licensed health care professionals.

Treatment programs in California will continue their agreements with allied health facilities to provide TB testing and TB test evaluations. In some instances, treatment provider staff are certified as TB skin test clinicians (individuals must meet the requirement specified in the California Health and Safety Code beginning with Section 121360). California TB skin test clinicians can only administer the skin tests; interpretation of the results is limited to licensed health care professionals. Licensed health care professionals deemed capable to interpret TB skin tests are physicians, registered nurses, physician assistants, and nurse practitioners. In addition, licensed vocational nurses and medical assistants who are TB certified and work in TB clinics may also interpret skin tests.

ADP's State Medical Director for Substance Abuse Services will provide medical expertise, analysis, advice and guidance on medical and policy issues associated with TB and other infectious diseases.

In addition, ADP will work with California Department of Public Health (CDPH) tuberculosis liaison to ensure education in appropriate treatment and infection control is provided in substance abuse programs. As a disease control measure, substance abuse treatment providers will be required to obtain a physician or health care provider's clearance for clients who are diagnosed with tuberculosis prior to admission for AOD treatment.

CDPH will distribute appropriate client and other information to county health departments. County alcohol and drug program administrators will work closely with county health

departments, which oversee TB control activities, to ensure all federal block grant requirements are appropriately met.

ADP county liaisons and licensing analysts will provide ongoing technical assistance (TA) to each county to ensure adherence to federal block grant requirements.

ADP's Performance Management Branch (PMB) will conduct annual compliance reviews of all county administrative systems to ensure compliance with SAPT funding requirements.

Human Immunodeficiency Virus (HIV) Services

In accordance with 42 U.S.C. §300x24(b) and 45 C.F.R. §96.128, ADP ensures that human immunodeficiency virus (HIV) early intervention services (EIS) requirements will be met through a county-based system in California. Meeting these requirements will be "operationalized" through the Negotiated Net Amount Contracts between ADP and the counties. The NNA contracts will include Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements for HIV EIS, and will authorize the counties to spend funds in accordance with federal statutes, regulations, guidelines and State requirements.

ADP will allocate HIV set-aside funds to counties annually. The allocation will include at least one county with a program in an urban area and one county with a program in a rural area. California will distribute at least $7,500 to each of the participating counties, so the least populous counties have sufficient funds to provide a basic HIV EIS program. Participant counties locally contract to provide HIV EIS.

ADP will distribute 100 percent of the HIV EIS funding to 51 of the 58 counties. Six counties (Alpine, Calaveras, Colusa, Mariposa, Plumas, and Trinity) have minimal need for HIV EIS funds and declined these funds in the past. ADP does not anticipate a change in need during FY 2012-2013 for these counties. ADP requires counties that elect not to receive HIV funds to indicate in writing how the need for HIV services will be met using non-SAPT funding.

As in past award years, ADP will utilize the California Department of Public Health, Office of AIDS (CDPH-OA) needs-based methodology to allocate HIV set-aside funds. The methodology incorporates HIV and IVDU prevalence, at-risk populations, and other risk factors. HIV funds will be allocated using these indicators:

1. 40%: Number of Newly Reported HIV Cases (2007 to 2009)
2. 20%: Cumulative Living AIDS Cases Through December 31, 2010
3. 15%: African American population (2010 U.S. Census)
4. 7.5%: Male Syphilis Cases, 2009
5. 7.5%: Male Gonorrhea Cases, 2009
6. 5%: Hispanic population (2010 U.S. Census)
7. 5%: People Living Below Federal Poverty Line (U.S. Census Data 2009 Estimates)

The Number of Newly Reported HIV Cases refers to the cumulative sum of positive HIV tests (with no indication of a previously positive result) in the three most recent years of complete data reported to the State. Because the funding is based on need, there is a

possibility that the amount each county will receive might change annually. ADP will review allocations and county cost reports to determine compliance with the five percent minimum and maximum set-aside amount for HIV services and to ensure that at least one program is in a rural area. ADP will monitor county systems, including provider subcontracts, through on-site visits to ensure compliance with federal HIV requirements and take appropriate action if instances of noncompliance are identified.
ADP will continue to collaborate with CDPH-OA to promote HIV/AIDS prevention and treatment services and will maintain access to pre- and post-test HIV counselor training by alcohol and other drug service providers and county alcohol and drug program staff. CDPH-OA is responsible for monitoring HIV counseling and testing for compliance with state and federal statutes, regulations, and policies. CDPH-OA has requested input from the County Alcohol and Drug Programs Administrator's Association of California (CADPAAC) to participate in a focus group to target at-risk populations and to identify effective strategies for delivering HIV EIS services.

To ensure that ADP will expend its FFY 2012-2013 HIV set-aside funds while providing the most effective early intervention services, ADP will continue its practice of redirecting HIV set-aside funds from under-expending counties. It will also continue its collaboration with CDPH-OA and its role with CDPH-OA's HIV services planning group. ADP plans to improve its HIV early intervention services by identifying best practices for providing EIS and targeting priority populations. ADP is also planning to improve outreach and prevention services for target populations via a possible collaboration with OA's mobile testing units.

Pregnant Women Preferences

In accordance with 42 U.S.C. §300x27 and 45 C.F.R. §96.131, ADP ensures that substance abuse services, including preferences in treatment services to pregnant women, will be provided through a county based system in California. The Negotiated Net Amount (NNA) contracts entered into between the Department of ADP and the counties will incorporate by reference the requirements to provide admission preference, referral, and interim services to pregnant women. The *Perinatal Services Network Guidelines (2009)* will also be incorporated by reference into the NNA contracts. By signing and submitting the contracts, counties will indicate compliance with these requirements. All Perinatal Service Network (PSN) programs, regardless of funding source, will be required to comply with the PSN Guidelines as specified by the NNA contract between the state and the counties. The requirements include, but are not limited to those outlined below:

Perinatal Program Requirements

A. Target Population
To be eligible for perinatal funding, a program must serve women who are either:
- pregnant and substance using; or
- parenting and substance using, with a child(ren) ages birth through 17.

Parenting also includes a woman who is attempting to regain legal custody of her child(ren).

B. Admission Priority (45 CFR 96.131)

Priority admission for all women in perinatal funded services must be given in the following order:

1. pregnant injection drug users;
2. pregnant substance users;
3. parenting injection drug users; and
4. parenting substance users.

A program's admission criteria must comply with the Americans with Disabilities Act (ADA) of 1990. Specific information regarding the ADA is contained in each county's NNA contract.

C. Referral to Other Programs and Interim Services (45 CFR 96.121 and 96.131)

1. When a program is unable to admit a substance-using pregnant woman because of insufficient capacity or because the program does not provide the necessary services, referral to another program must be made and documented.

   Pregnant women must be referred to another program or provided with interim services no later then 48 hours after seeking treatment services. Pregnant women receiving interim services must be placed at the top of the waiting list for program admission.

2. Injection drug-using women must be either:
   a. admitted to a program no later then 14 days after making the request; or
   b. admitted to a program within 120 days after making the request, if interim services are provided.

3. To assist programs in making appropriate referrals, each county must make available a current directory of its community resources.

4. Interim services are defined as:
   a. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB), the risks of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
   b. Referrals for HIV or TB treatment services, if necessary.
   c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care.
   d. Referrals based on individual assessments that may include, but are not limited to: self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, children's services, medical services, and Temporary Assistance to Needy Families (TANF)/Medi-Cal services.

The NNA contracts also require counties to maintain a system for monitoring the number of referrals made and interim services provided by each program. ADP's Performance Management Branch (PMB) staff will conduct county monitoring annually to ensure appropriate processes are in place to comply with these requirements.

PRIMARY PREVENTION SERVICES STRENGTHS AND NEEDS

"Research shows preventing drug use before it begins is the most cost-effective, common-sense approach to promoting safe and healthy communities. Prevention results in better academic performance among teens who don't use drugs, fewer auto accidents from reduced drugged driving, and more productive workplaces due to lower absenteeism. Preventing drug use also lowers HIV-transmission rates due to decreased injection drug use, creates safer home environments for children previously considered drug-endangered, and revitalizes neighborhoods due to coalition-based efforts. Put simply, drug prevention saves lives and cuts costs."[2]

ADP's statewide priorities related to prevention services are intended to develop the necessary infrastructure of ADP in order to target behavioral change at a statewide level. Goal 1 under State Priority 3, as described in Table 3, will result in statewide prevention priorities/outcomes that are behavior-based rather than process-based. Although these have not been finalized, alcohol use by youth will be the primary focus.

Services to Youth

According to the report Adolescent Substance Use: America's #1 Public Health Problem released by The National Center on Addiction and Substance Abuse (CASA) at Columbia University in June, 2011, 90 percent of Americans who are suffering from addiction started smoking, drinking, or using other drugs before the age of 18, and underscores the fact that addiction is a disease with adolescent origins. The CASA report finds that 1 in 4 Americans who began using any addictive substance before age 18 are addicted, compared to 1 in 25 Americans who started using at age 21 or older.

In order to reduce the age of onset, ADP intends to continue to focus on alcohol, tobacco, and other drugs (ATOD) prevention services to youth through the FNL system, Student Assistance Programs, educational services, ATOD screenings, and programs aimed at reducing risk factors and increasing protective factors. Two of the statewide priorities/outcomes being developed by the ADP/CADPAAC Prevention Subcommittee focus on youth and alcohol use.

FNL is an example of a statewide prevention delivery system based on three evidence-based youth development frameworks that actively engage young people in program decision-making, assessment, planning, and implementation, in order to deliver programs that foster autonomy, safety, community partnerships, youth/adult partnerships, and demonstrate cultural and civic competence, all of which research identifies as key to their success. Combining these strategies works to reach both goals of underage ATOD problem reduction and providing youth leadership opportunities that lead to positive youth, school, and community outcomes. FNL participants across the state are working to change their schools and communities to limit access, engage stakeholders, and ameliorate the pro drinking and drug taking cultural norms that promote ATOD use and underage access to ATOD.

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[2] Office of National Drug Control Policy website, A Comprehensive Approach to Drug Prevention (http://www.whitehouse.gov/ondcp/prevention-intro)

Each FNL county program must meet the Members In Good Standing (MIGS) requirements to ensure fidelity of the programs to stay true to the three evidence-based frameworks. One of the MIGS requirements is to implement youth-led environmental prevention strategies. Other requirements of the MIGS, such as participation in cross-site evaluation activities, are intended to move the FNL system towards outcomes-based programming. The FNL program recently won SAMHSA's Service To Science Award to become nationally recognized as an evidence-based strategy and will continue to work toward that recognition.

The California FNL Partnership (CFNLP) is partnering with Allstate Foundation on a Distracted Driving Campaign. In September 2011, Allstate, CFNLP and the California Youth Council will collaborate on a Youth Traffic Safety Summit that will address youth traffic safety issues including distracted driving, seatbelt safety and underage drinking. The CFNLP will continue to seek partners and leverage funding to provide California's youth with the skills and opportunities to become future leaders in our communities, states, and nation.

Services to Individuals Who Live In Rural Areas

Ninety percent of California's population resides within 22 of California's 58 counties. The majority of the other 36 counties are considered rural or frontier. Although California doesn't target individuals who live in rural areas on a statewide level, these counties receive SAPT Block Grant Primary Prevention Set-Aside funds to provide services that will ultimately impact these individuals. Each county addresses the challenges and needs of its population(s) as identified in its needs assessment. An example of a program serving these individuals is the Santa Ynez Valley (SYV) Coalition to Promote Drug Free Youth-Substance Abuse Reduction and Prevention Program. The Coalition to Promote Drug-Free Youth serves an area with a population in excess of 30,000 and is predominantly rural in nature dominated by vineyards, horse ranches, cattle range, farms and the Los Padres National Forest. According to federal guidelines, the area is suburban and includes the tribal reservation of the Santa Ynez Band of Chumash Indians. The rural nature of the area and isolation of many residents has made it fertile ground for the manufacture of methamphetamine, production of marijuana, and concealment of underage drinking. The goals of the Coalition are: 1) reduce substance abuse among the Valley's youth and ultimately among adults by increasing barriers to access, establishing consequences for providing alcohol and other substances or venues for use, adopting policies to effect social norms, and educating youth and adults regarding risks and harms of use; 2) increase and strengthen collaboration among the area's community sectors including county and local governments, the Santa Ynez Band of Chumash Indians, business and service groups, schools, private non-profit agencies, parents, youth, religious organizations, media and grass roots community groups in an effort to reduce substance abuse among youth. To achieve these goals, the Coalition will implement the following strategies: develop a social host liability ordinance for adoption by local governments; increase adoption of a "safe house-no host" parent pledge; establish a public education media campaign to increase awareness of youth drug problems and consequences, work with law enforcement to develop and coordinate teams to respond to underage drinking parties and events that attract underage drinkers, and provide safe supportive activities for at risk youth.

Services to Youth in Tribal Communities and Among Military Families

The SEW is planning on soliciting membership from individuals who are involved with AOD-related data for California tribes to increase the cultural competence of the SEW. The CFNLP is collaborating with the National Guard to target services to military families and their children as well as designing a FNL mentoring program specifically for the Native American culture. And, based on local needs assessments, each county will target this population using evidence-based programs, if appropriate. For example, in Alameda County, the Native American Health Center Inc. Youth Services Program works on four levels: individual, family, school/peers and community/environment. The program is designed to build resiliency factors by teaching positive health habits, strengthening families through parent involvement, counter peer pressure by developing youth role models, and by creating a healthy environment that maximizes participation in positive social activities with an outcome of lowering the risk of youth becoming involved in AOD use. The program is a comprehensive, culturally appropriate continuum of care that targets Native American youth as well as a broad spectrum of youth from all ethnic backgrounds. The rationale for the youth efforts is based on culturally relevant adaptation of prevention methods that minimize risk factors and strengthen resiliency factors.

Technical Assistance to the Prevention Field

Through the Community Prevention Initiative (CPI), ADP contracts with the Center for Applied Research Solutions to provide technical assistance to ADP Prevention Services Branch and the prevention field free of charge. In FY 2012-2013, CPI, under ADP's guidance, will develop curricula on core competencies and provide regional trainings on:

- the SPF and the Institute of Medicine's universal, selective, and indicated prevention categorizations;
- identifying and selecting appropriate evidence-based strategies;
- engaging in environmental and community-based prevention;
- engaging coalitions in community prevention efforts;
- preparing counties and communities for health reform; and
- topic-specific trainings, webinars, resource documents, and technical assistance to counties, providers and organizations.

CPI will continue to provide culturally relevant services including multilingual materials, curriculum trainings, and responsible beverage service trainings as well as offer a wide range of consultants who are proficient in languages other than English and who are sensitive to the needs of underserved populations and race/ethnicities.

Evidence-Based Strategies, Policies, Programs, & Practices

ADP Prevention Services Branch will continue to require that counties consider the use of evidence-based strategies, policies, programs and practices (EBPs) in their strategic planning process. Use of EBPs are tracked through CalOMS Pv. EBP-specific trainings and technical assistance are provided at no cost to California's ATOD prevention field.

Currently, two county-level and one statewide program developed in California are working toward obtaining national recognition as evidence-based programs on SAMHSA's National Registry of Evidence-Based Programs list. Technical assistance is provided by CPI and SAMHSA's Service to Science Award.

As mentioned earlier, ADP's SPF SIG workgroup will provide a mechanism to support identification of evidence-based policies, programs, and practices (EBPs) that are culturally relevant at the community level. This will lay the groundwork for implementation of the SPF and use of EBPs on a statewide level.

Data Collection

CalOMS-Pv

ADP's PSB assists counties in uploading their SPF-based prevention plans and inputting specific goals and objectives into CalOMS-Pv. This web-based service, provided through KIT Solutions, LLC, serves approximately 300 providers, 58 of which are counties. CalOMS-Pv incorporates the three Institute of Medicine (IOM) categories as well as the six Center for Substance Abuse Prevention (CSAP) strategies and their related services. Providers link their activity data to objectives identified in the county strategic plan which are assigned to them by their respective counties. More than 70 standard data reports are available to users to assist them with monitoring, reporting, planning, outcomes, sustainability, and standard operations. A new dashboard will be implemented which will alert county and provider sites when any contractual reporting requirements are not being met.

California Healthy Kids Survey/ California Student Survey (CHKS)

ADP and the California Department of Education (CDE) co-sponsor the CHKS, a powerful tool for use in Grades 5-12 that can help schools, districts, and local planning offices accurately identify areas of student and school strengths and weaknesses, and address related needs. It provides a comprehensive, data-driven, decision-making process to guide efforts to improve school climate, learning supports, and engagement, as well as identify and increase the quality of health, prevention, and youth development programs. County AOD offices and prevention providers rely on this survey as a source of local data for their needs assessment.

At the heart of the CHKS is a broad range of key learning and health-related indicators that are used to collect student data on attitudes, behaviors, and experiences related to school and learning. School connectedness, developmental supports and opportunities, safety, violence and harassment, substance use, and physical and mental health are some of the key areas assessed by the survey.

The research-based assessment of factors that promote resilience and positive youth development is one of the survey's many unique benefits. Additionally, the CHKS can be customized by schools and districts to meet local needs. The survey includes a general, core set of questions, plus a series of supplementary modules covering specific topics. Schools can add questions of their own choosing or creation on other topics of local interest via a search feature that identifies questions previously used by other schools. The

customizability of the CHKS allows schools and districts to receive relevant, useful knowledge tailored to their needs. The CHKS surveys approximately 800,000-1,000,000 5th, 7th, 9th, and 11th graders.

The California Student Survey (CSS) dates back to 1985 and provides statewide trend data on AOD use and perceptions. The CSS includes all questions in the CHKS core module as well as on other topics identified as a priority. The CSS surveys approximately 10,000-14,000 7th, 9th and 11th graders.

In 2007, both the CHKS core module and the CSS were modified to include all the questions on Tables 23-27, 31, and 32 in the FY 2012 Block Grant Reporting Section. With the loss of Title IV funds and reduced funding statewide, the futures of the CHKS and CSS were unknown. In 2011, ADP was able to identify SAPT funding to continue the CSS and provide infrastructure support for the CHKS; however, reduced funding at the local level may still create roadblocks to acquiring this data for all communities. ADP will continue to make funding of these surveys a priority as they are critical to both local and statewide needs assessments.

Tobacco

Under the Stop Tobacco Access to Kids Enforcement (STAKE) Act, California law requires that $2 million of the annual SAPT Block Grant be transferred to the Department of Public Health (DPH) to comply with the Synar requirement. ADP's Prevention Services Branch will continue to work with DPH on prevention of underage tobacco use in support of the STAKE Act. In 2011, California's rate of tobacco sales to minors dropped to 5.6%, even lower than 2010's rate of 7.7%. ADP's Resource Center will continue to distribute publications, books, videos, and curricula on tobacco use prevention. Local programs also address tobacco issues.

Workforce Development

Great progress has been made in researching and understanding the causes and consequences of substance abuse. Evidence-based prevention practices and research continue to be identified. However, relevant findings, knowledge and skills often are not effectively disseminated to front-line workers and other prevention program staff. High staff turn-over rates, lack of a formal certification process and no/or inadequately focused trainings all contribute to this problem. It has been increasingly recognized that effective application of prevention programs requires an educated and skilled workforce, including both managers and prevention providers at the front-line worker level.

To strengthen the workforce, the PSB defined prevention competencies to help ameliorate these problems. Establishing competencies will provide focus for ensuring best prevention practices are known, implemented and used by the prevention field. However, simply developing a list of competencies is insufficient to ensure adoption and use by prevention workers. Therefore, PSB is also implementing a structure or framework to support the field in the acquisition of the competencies. PSB is working with technical assistance and training contractors to develop and implement a training agenda focused on competencies

as well as deliver the content. This includes the development of online and onsite training materials. The agenda ensures that the field is oriented, informed and engaged in providing input as the competencies and training are developed.

The competencies integrate both the International Certification and Reciprocity Consortium (IC&RC) and Center for Substance Abuse Prevention (CSAP) domains and are reflective of the diverse approaches and workforce in California. Next year, three regional trainings and a minimum of six online training courses will be conducted on competencies for prevention. These prevention competencies include:

Core (those that ensure data driven planning, evidence-based implementation and outcome-based decision making)

- Assessment
- Capacity
- Planning
- Implementation
- Evaluation

Foundational (those that are "cross-cutting")

- Prevention Theories and Frameworks or Key Concepts in Prevention
- Cultural Competence and Responsiveness
- Sustainability
- Professional Growth, Ethics and Responsibility

Specialized (those that tend to be more specific to a particular prevention strategy or approach – can be added to over time)

- Skill Building
- Environmental Prevention and Public Policy
- Youth Development
- Screening and Brief Intervention

With the implementation of the Affordable Care Act, it will be critical that the health care workforce be knowledgeable and prepared for the increase in individuals needing AOD prevention services. As indicated under Priority #3, Goal #2, ADP intends to make this curricula available to the AOD field and eventually market it to other systems (mental health and primary care).

Affordable Care Act and Prevention Services

With the passage of the ACA in 2010, the Nation's health care system is being redesigned to increase coverage for more Americans and reduce health care costs, in part, by preventing health problems from occurring throughout all stages of life. The recently released National Prevention Strategy identifies seven priorities addressing the most serious threats to health: Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use, Healthy Eating, Active Living, Injury and Violence Free Living, Reproductive Health, and Mental and Emotional Well-Being.

The Office of National Drug Control Policy (ONDCP) Director, Gil Kerlikowske stated that the ONDCP Drug Policy "recognizes that the most promising drug policy is one that prevents drug use in the first place."[3]

> "Scientific evidence makes clear that drug prevention is the most cost-effective, common-sense approach to promoting safe and healthy communities. Youth who refrain from drug use have better academic performance.[14] Communities enjoy reduced drugged driving and, therefore, safer roads. Employers experience lower absenteeism, resulting in more productive workplaces.[15,16,17] Drug use prevention efforts also impact HIV transmission rates by decreasing injection drug use, creating safer home environments by reducing the number of drug-endangered children, and revitalizing neighborhoods through coalition-based efforts.[18,19,20]" (ONDCP, National Drug Control Strategy 2011, pg. 4)

The National Prevention Strategy, the National Drug Control Strategy, as well as Healthy People 2020 provides the Department with a framework for identifying new partners and garnering support for AOD prevention efforts within the context of wellness and improving business operations to support counties and local prevention providers. ADP's Prevention Services Branch will continue to provide assistance and information to local communities and counties so they are more competitive for funding as well as facilitating collaborative opportunities so critical to expanding AOD prevention services under the ACA in California.

To this end, Prevention Services Branch developed a strategic plan for incorporating AOD prevention in, and implementation of, the ACA with accompanying weighted criteria for selecting and achieving priorities.

Area One: Business Operations Process – To develop, improve, and/or expand vehicles of communication, information dissemination, data, partnerships, and relevant news that support and enhance community prevention efforts.

- Sub-Area A: Improve information technology
- Sub-Area B: Increase utility of SPF county prevention plans for Health Reform preparation and expansion
- Sub-Area C: "Information Hub" – Collect, combine, and organize technical assistance tools and materials for dissemination

Area Two: Leadership and Relationship Building – Identify and Expand ADP's role in AOD prevention services during healthcare reform activities within California.

- Sub-Area A: State planning and decision making
- Sub-Area B: Relationship building
- Sub-Area C: Internal education
- Sub-Area D: Community education and awareness

Area Three: Improve and Expand Prevention Services – Promote effective and promising prevention practices and funding opportunities and share innovative community partnerships that demonstrate effectiveness.

[3] Statement from ONDCP Director R. Gil Kerlikowske *Why Marijuana Legalization Would compromise Public Health and Public Safety*, Annotated Remarks, Delivered at the California Police Chiefs Association Conference, March 4, 2010, San Jose, CA

Sub-Area A: ACA funding opportunities
Sub-Area B: Use of evidence-based practices and programs
Sub-Area C: Prevention partnership models
Sub-Area D: Form partnerships with organizations in healthcare

Area Four: Prevention Workforce Expansion – Prepare and expand the AOD prevention workforce.

Sub-Area A: Prevention workforce competencies
Sub-Area B: Continuing education for AOD Prevention Specialists
Sub-Area C: Explore the role of AOD Prevention Specialists

In addition, ADP Prevention Services Branch plans to:

- announce funding to local programs;
- explore state-level partnerships that will facilitate local partnerships;
- advance individual billable services as well as environmental services under Health Reform; and
- explore more research-based, scientific prevention services that can be billed.

Information and Education

ADP Prevention Services Branch will continue to operate the Resource Center, the only ATOD dedicated clearinghouse and resource center in California. With reductions in funding, providing these resources free of charge to the public and ATOD field is more important than ever. The Resource Center is also looking into various forms of social media/marketing such as YouTube, FaceBook, Twitter, and Google+. These media tools will enable ADP to help advance ATOD prevention and health reform by providing real time information on funding opportunities, news sources, and AOD prevention initiatives identified by the SAPT Block Grant, SAMHSA, ONDCP, CDC and other agencies and organizations.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

California's Changing Environment

A component of assessing need is acknowledging and understanding the environmental changes that occur and factoring that into the discussion surrounding a data-informed decision-making process. The current state of the economy, along with the massive changes in the nation's health care system and the shifting federal focus creates significant challenges and opportunities for the substance abuse field in moving the system in a direction that leverages scant resources while providing effective services for clients. Following is a discussion of the major environmental factors that will impact policy-setting and decision-making for the substance abuse field in the foreseeable future.

Budgetary Considerations

In the past few years the tremendous economic downturn has undercut the state's ability to maintain a stable level of funding for necessary publicly-funded services in many service sectors. Declining revenues coupled with increases in the need for services due to record high unemployment have lead legislative leaders to consider different methods of revenue generation, such as the legalization of marijuana and increasing alcohol taxes.

For California's system of publicly-funded substance abuse services, the budgetary shortfalls have resulted in the loss of significant funding to serve the offender population, however the requirement to serve this population remains in effect.

County efforts to maintain services during this economic downturn have lead to hard decisions at the local level. Those decisions have included shortening lengths of stay in treatment, reevaluating use of higher cost treatment modalities, and instituting or maintaining longer waiting lists. Conversely, it has also led some counties to leverage available resources through local partnerships and increase effectiveness through the implementation of process improvements and evidence-based practices.

The negative consequences of the budget shortfalls are evident. It is more important than ever to institute cost-effective ways to support individuals in need of services and to pool resources where possible. While the budgetary issues are significant, challenging times such as these can foster innovative solutions, unlikely partnerships and more cost-effective business practices.

The Health Care System and Reform

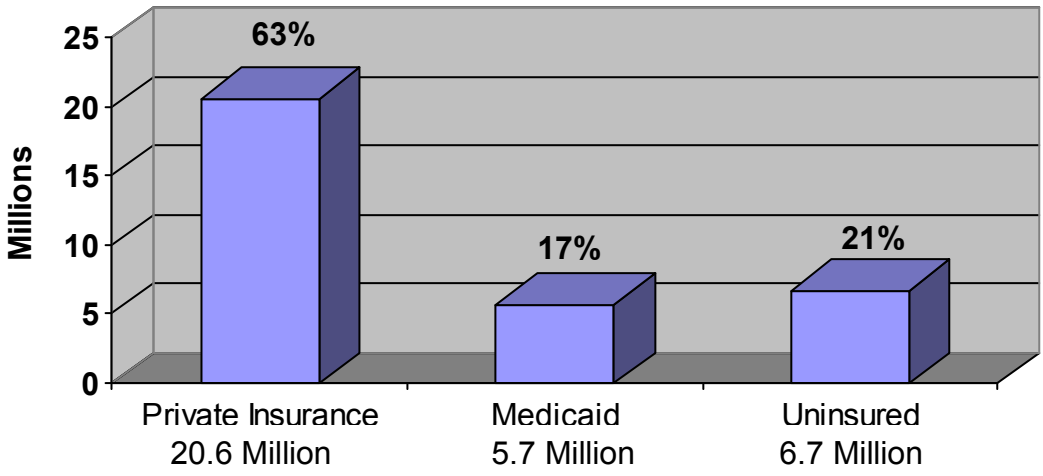
Nearly four and a half million uninsured Californians will become insured in 2014

On March 23, 2010, the President signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), legislation which seeks to reform the nation's health care

system. This law requires major systems change efforts on the part of the substance use field in order to flourish under the law's provisions. Basically, the law will substantially increase the pool of insured individuals, expand public benefit programs (e.g., Medicaid), support community-based services, enlarge the health-related prevention focus, support providers' transition to electronic medical records, improve quality and accountability of the service delivery system, and integrate substance abuse services with primary health care.

It is estimated that once the law is implemented in 2014 exponentially expanding the number of insureds, 94 percent of Californians will be insured, either through their employer, a new health insurance exchange market, or expansions to public benefit programs.[1] This means that six percent of Californians will remain uninsured or (using today's population numbers) approximately 2.3 million people. Using the following 2008 data as a gauge to calculate a rough estimate, nearly four and a half million uninsured Californians will become insured in 2014.

2008 CA Health Insurance Coverage for the Nonelderly (under age 65) Population

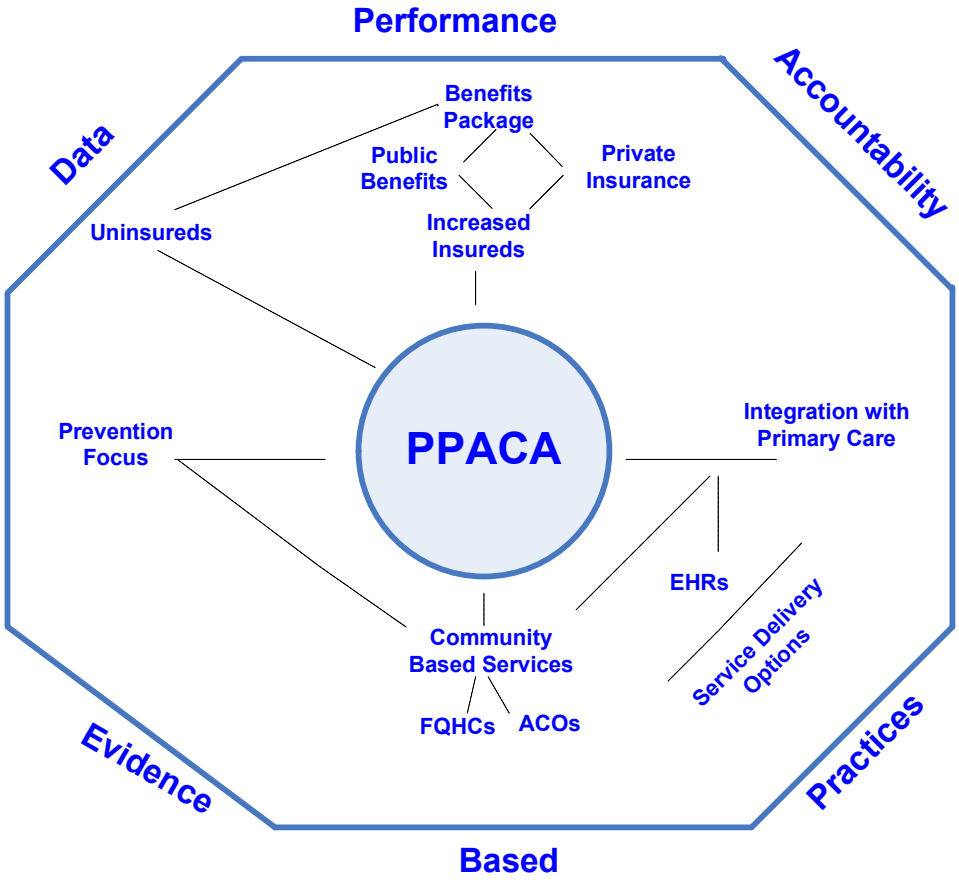


Source: CA Healthcare Foundation www.chcf.org

This could have a significant impact on the AOD system in California as the most prevalent reason that people in need of treatment cite for not receiving treatment is that they do not have insurance or the financial means to afford treatment. It is unknown at this time how many of these newly insured individuals will be able to receive services for their substance use conditions through the primary care system and how many will need a specialty care provider.

[1] California HealthCare Foundation. (May, 2010). *The Affordable Care Act: What Californians Should Know.* Retrieved from http://www.chcf.org/~/media/Files/PDF/A/PDF%20AffordableCareActWhatCAShouldKnow.pdf

The changes that will be required are significant. Following is a simplified diagram of basic impact areas of the PPACA that must be considered in our planning processes.



Source: Performance Management Branch, Department of Alcohol and Drug Programs, August 2010

The issue becomes much more complex when interpreting what these areas mean for the AOD field. For example, considerations in the area of health insurance expansion:

- Medicaid, the public benefit, is expected to expand considerably, estimates suggest nearly two million additional Medi-Cal eligible individuals in California. It will become a major payer of substance abuse services; therefore, building the capacity to bill for services through the Medicaid system is critical. As will the ability to provide services in line with the Medicaid rules and regulations, provide wraparound services to ensure effective practices are in place, and ensure the AOD workforce has the necessary licensures and other credentials necessary to provide services within the Medicaid system.
- The number of privately insured individuals will potentially expand by nearly three million people in California. This greatly increases the chances of identifying individuals with substance abuse issues through the primary care system. It will be critical to partner with the primary care system to ensure: 1) appropriate AOD

screening is in place to identify individuals with substance use issues; 2) linkages exist between the primary care and AOD system to ensure a seamless referral process for those individuals identified as needing treatment, as well as linking through electronic health records; 3) educating primary care doctors/staff in appropriate prevention strategies: and 4) ensuring the AOD workforce has the necessary licensures and other credentials to be reimbursed for services from private insurers.

- The number of uninsured individuals in California will be significantly reduced, however, at approximately 2.3 million people, there will still be a substantial number that may need services but have no financial options for obtaining it. A safety net will still be required for individuals needing treatment with no financial resources.

The above is a very brief discussion of PPACA impacts to the AOD field. There is much work to be done and questions still to be answered to understand the full scope of the impacts. However, we do have a basic map that can guide our preparation in order to take full advantage of this unique opportunity to broaden the AOD field to include many more options for clients.

The Medicaid 1115 Waiver

In preparation for the implementation of major portions of the PPACA in 2014, California submitted their 1115 Waiver to the Centers for Medicaid and Medicare Services (CMS) with the goal of health care reform readiness in mind. California's approved 1115 Waiver requires the development of a Behavioral Health Needs Assessment (BHNA) be completed by March 1, 2012 detailing the state's current behavioral health system and the anticipated growth required to meet all Medicaid expansion needs by 2014. A subsequent plan based on the BHNA is due to CMS by October 1, 2012. Since the state anticipates close to two million additional Californians will be eligible for Medi-Cal in 2014 the Assessment and Plan are critical elements to ensuring behavioral health services will be available for the additional Medicaid population.

The Federal Direction for Alcohol and Drug Abuse

Primary health care will be a major entry point for the provision of treatment for substance use disorders.

Over the last several years the Substance Abuse and Mental Health Services Administration (SAMHSA) has been developing and implementing the National Outcome Measures (NOMs) for prevention and treatment of substance use and mental disorders. The development of the NOMs has been an effort on SAMHSA's part to capture standardized outcome data across states to measure outcomes in important life domains of clients as well as traditional prevention and treatment measures. The intention of the NOMS is performance management, the utilization of data to improve programs and services. Ultimately, the NOMs data is being positioned to serve as the measure of prevention and treatment effectiveness, accountability and efficacy of programming.

In addition, to continue improving the delivery and financing of prevention, treatment, and recovery support services, SAMHSA has identified 8 Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities.

In addition to SAMHSA's efforts, the Office of National Drug Control Policy (ONDCP) has collaboratively developed the 2010 National Drug Control Strategy that takes into account the latest scientific evidence and innovations in the prevention, treatment and law enforcement fields. The implementation of the *Strategy* calls for a collaborative effort of local, State, tribal, Federal agencies, community-based organizations, and other nongovernmental partners.

Together, the *Initiatives* and *Strategy* map out the federal direction related to prevention, treatment and interdiction efforts related to substance use and abuse. Central to both plans is the premise that primary health care will be a major entry point for the provision of treatment for substance use disorders.

The unmet service needs identified in the assessment below is from the 2010 California Needs Assessment Report. The data will be updated in the 2011 California Needs Assessment Report (NAR) which will be available in December 2011. Specific unmet service needs for the Medicaid population will be detailed in the Behavioral Health Needs Assessment (BHNA) which will be completed by March 1, 2012 as a required component of California's approved 1115 Waiver. The 2011 NAR will be updated to reflect the findings in the BHNA after its release next year.

Assessment of the Continuum of Need

A variety of methods is used to estimate the population in need of AOD services in California. The level of need is assessed and identifies areas where there appears to be a gap between the need for services and the services currently being provided.

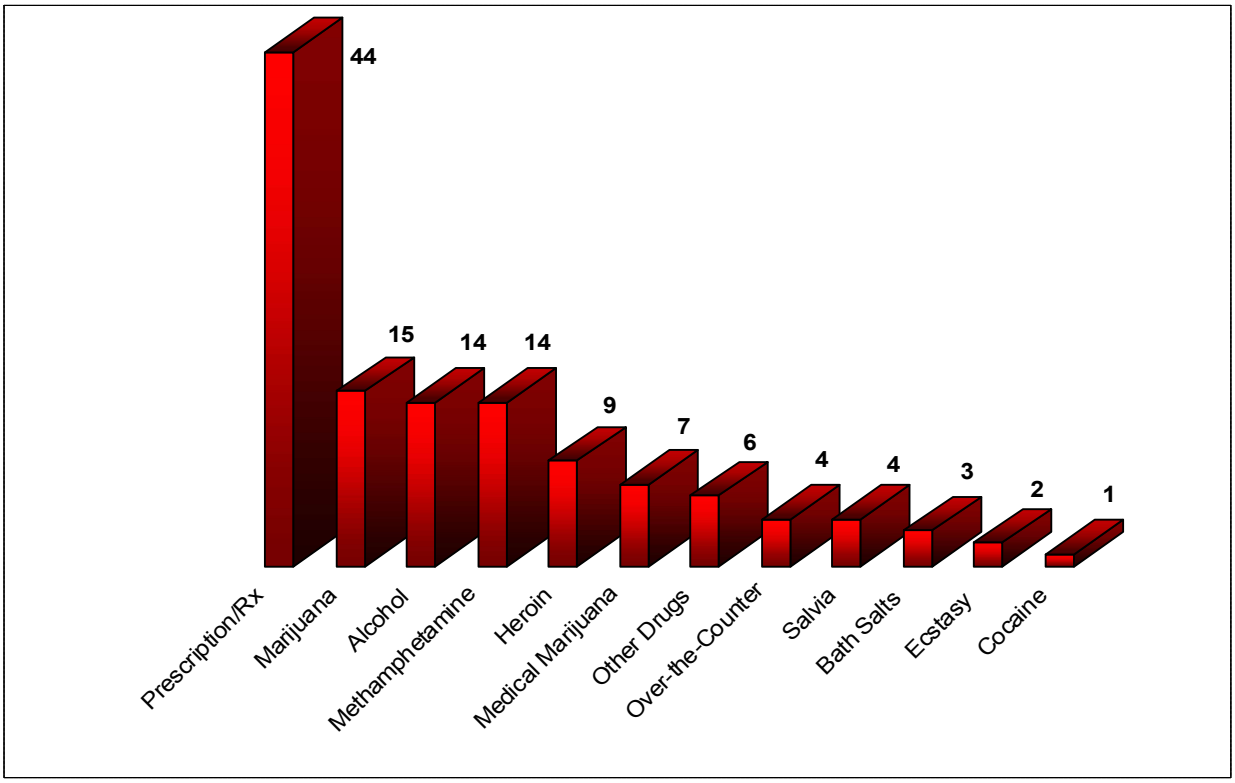
The first section below indicates the emerging trends that are reported by the counties. The sections following emerging trends address estimates of the broader need for prevention and early intervention services which, to the degree that these services are effective, will impact the future need for treatment services. The subsequent section focuses on estimating treatment need in order to assess the potential impact on the public AOD treatment services system.

The estimates produced here do not fully take into account the potentially vast, but not well understood, capacity of the private sector service system to provide both prevention and treatment services in the AOD field. As health care reform is implemented along with the implementation of mental health and substance abuse treatment parity, more uninsured people will become eligible for, and use, both public and non-public health insurance coverage for AOD services.

Emerging Trends

Counties identified their emerging trends such as new drugs of abuse, new methods of use, emerging drug-using populations, as well as identifying continued or increased use of specific drugs within their counties. This information is considered in projecting future statewide AOD needs.

The chart below identifies current AOD trends developing or increasing within California counties by number of 56 counties reporting that specific trend.



- 79% (44 of 56) Counties indicate an increase or continued use of Prescription Drugs
- 27% (15 of 56) Counties indicate an increase or continued use of Marijuana
- 25% (14 of 56) Counties indicate an increase or continued use of Alcohol
- 25% (14 of 56) Counties indicate an increase or continued use of Methamphetamine
- 16% (9 of 56) Counties indicate an increase or continued use of Heroin
- 13% (7 of 56) Counties indicate an increase or continued use of Medical Marijuana
- 11% (6 of 56) Counties indicate an increase or continued use other drugs. Other drugs include Methadone, Inhalants, Synthetic Drugs {Marijuana, Cocaine, Opiates}, and Wicked X {Herbal Smoke}
- 7% (4 of 56) Counties indicate an increase or continued use of Over – the – Counter drugs
- 7% (4 of 56) Counties indicate an increase or continued use of Salvia
- 5% (3 of 56) Counties indicate an increase or continued use of Bath Salts
- 4% (2 of 56) Counties indicate an increase or continued use of Ecstasy
- 2% (1 of 56) Counties indicate an increase or continued use of Cocaine

PREVENTION

Due to lack of resources, there is a substantial gap between what is currently in place in terms of prevention strategies, policies, and programs and what is actually needed to meet the substance abuse prevention needs of California's population. The gap in prevention services is especially critical for the publicly-funded system. ADP serves as the leader in addressing the continuum of substance abuse problems. By establishing prevention strategies that minimize AOD use and abuse, more costly treatment can be avoided.

Evidence-Based Prevention Strategies

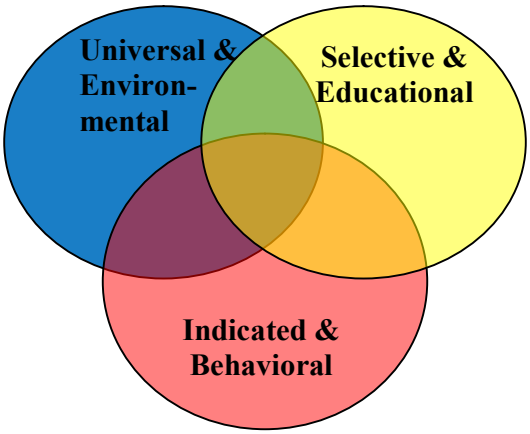
The following discussion will serve to provide the context for the determination of the prevention services need in California. In order to determine the prevention services need in California, an understanding of the types of prevention strategies effective for the various target populations is necessary.

Given that substance abuse and dependence has a wide range of adverse consequences and society has limited resources, we need to be as efficient as possible in preventing and delaying initiation of substance use and reducing the harmful consequences their use. Prevention is defined by the Institute of Medicine Continuum of Care as serving three levels of risk categories. Universal preventive interventions are targeted to the general public or a segment of the entire population with an average probability of experiencing adverse AOD consequences and/or developing a substance use disorder. Selective preventive interventions are targeted to specific populations whose risk of adverse consequences or substance disorder is significantly higher than average, either imminently or over a lifetime. Indicated preventive interventions are targeted to designated individuals who have minimal but detectable signs or symptoms suggesting a disorder or who carry biological markers for a disorder often referred to as high risk.

In California's diverse environments and cultures, it is clear that interventions addressing only one level of risk will not be sufficient to reduce the problem. Thus, a comprehensive package of prevention policies, strategies and programs conducted at all three risk levels is required. "Given the number and diversity of proven interventions, optimal resource allocation requires selecting the most complementary, politically feasible, and culturally and demographically appropriate set to maximize a return on investment within the available funding. Of critical concern is to identify a sensible package of interventions that complements existing interventions."[2]

[2] Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis,* DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

Effective Prevention is Comprehensive



For example, two of the risk prevention approaches are often set against each other: universal population-based approaches versus indicated interventions with a focus on high-risk users.

- Population: change majority, the *conditions* that shape *everyone's* behavior.
- High-risk: change extreme, high-risk individuals, treatment may be needed

It is important to stress that these approaches are NOT mutually exclusive. Not only is it possible to do both, but it is an essential part of a comprehensive approach to do both.

Each approach has its advantages and disadvantages. For the population or public health approach the potential advantages are:

- Large population benefits
- Broad target audience
- Longer lasting effects

And the potential disadvantages are:

- May limit personal freedoms
- Resistance from invested parties
- Counter-intuitive

Using an alcohol example, the Prevention Paradox demonstrates the counter-intuitive aspect of the public health approach. Although the greatest risk of health harms occurs among extreme drinkers, but there are relatively fewer extreme drinkers compared with the many more "moderate" drinkers. "Moderate" drinkers are also at risk. Given these numbers, the majority of health harms in a college setting arise among students who drink at *moderate or low* levels. Thus, the greatest health benefits are gained from incrementally moving the majority to lower and less risky consumption patterns.

This research literature has documented consistent findings of effective universal policy and environmental strategies[3], including:

- **minimum drinking age laws**
- **driving under the influence laws**
- **enforcement of existing laws**
- **increased alcohol taxes**
- **responsible server training**
- **reduced density of alcohol outlets**

For the high-risk approach the potential advantages are:

- Intervention tailored/targeted to the individual
- Clear benefits (when achieved) to the individual
- Intuitive focus on the individual

And the potential disadvantages are:

- Difficult and costly to ID "at-risk" individuals
- Effects palliative, temporary
- Low odds of success
- Modest benefit to the population

A good example of the high risk approach is the School-based Student Assistance Programs that address high risk drug and excessive alcohol users.

Delay or Stop AOD Initiation

Prevention strategies directed toward youth are especially important because there is a strong potential to avoid substance abuse problems before they start. The research literature is extremely strong in documenting the value of stopping or delaying youth from ever starting to use. Currently at least 40 percent of young adolescents in 11th grade report not using alcohol or other drugs and less than half of youth under 14 report having used any substance.

For illustrative purposes, the universal implementation of effective school-based prevention programs[4] is used as an example to demonstrate the potential value-added of prevention services. The rationale is that "Nearly every youth ages 12–14 is at risk for trying alcohol, tobacco, and drugs and may be aware of social norms and feel peer pressure to start using these substances." Universal implementation of effective school based prevention programs could delay from three to 25 percent of youth from starting to use.

[3] Institute of Medicine of the National Academies. Division of Behavioral and Social Sciences and Education. *Reducing Underage Drinking: A Collective Responsibility*, 2004. Available at http://books.nap.edu/openbook.php?record_id=10729&page=R1

[4] Ibid, Appendix pp 41-54.

EXAMPLE: Cost Benefit Analysis of Universal Implementation of Effective School-Based Prevention

This analysis of prevention needs and opportunities for California represents an initial effort to replicate the methodology and analyses conducted by Drs. Ted Miller and Delia Hendrie of PIRE published in *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis*[5]. Not only the analyses, but also this section text, borrow heavily from their work adapted to the California situation. This initial analysis is based on estimating the number of youth who would not have tried or would not regularly use these substances if effective school-based prevention programs were in place nationwide. To determine these estimates for California, the number of youth ages 12–14 was multiplied by the medium estimate of the percentage of youth who would delay initiating use of each substance if they received effective school-based prevention programming. The effectiveness estimates were drawn from two meta-analyses on the effectiveness of school-based youth substance abuse prevention programs[6].

Based on universal implementation of effective prevention programs in California in 2007, substance abuse initiation would have declined for nearly 100,000 of the 1,743,000 California youth 12-14 year old, and be delayed for two years on average.[7] As is well documented in the literature, a delay in onset reduces a wide range of subsequent problems later in life. Using prevalence data from the California Student Survey for 2007-08, an estimated:

- 3.1 percent fewer youth ages 12-14 would have engaged in drinking;
- 7.0 percent fewer youth would have used marijuana;
- 26.7 percent fewer youth would have used cocaine;
- 5.3 percent fewer youth would have smoked regularly.

Based on their review the average effective school-based program costs $220 in 2002 dollars (corrected to $255 for 2007 dollars) per pupil, including materials and teacher training. Implementing these programs universally throughout California could save an estimated $33 per $1 invested. Full implementation of school-based effective programming in 2007 would have reduced the social costs of substance-abuse-related medical care and other resources, and lost productivity and preserved the quality of life over the lifetime of those students affected for a total value of $14.8 billion.

Programs designed to strengthen families generally cost more than the school-based life skills programs. Several of them also were highly cost-beneficial and offered much larger returns in the aggregate per youth served than the school-based life skills programs. In a program targeting families with low income, intensive home visitation, coupled with preschool enrichment, reduced infant/toddler abuse (Aos et al., 1999; Karoly et al., 1998). As these toddlers reach adolescence and adulthood, these early visitation

[5] Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis,* DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.
[6] S. Aos, R. Lieb, J. Mayfield, M. Miller, A. Pennucci. (2004) Benefits and Costs of Prevention and Early Intervention Programs for Youth. Olympia: Washington State Institute for Public Policy, available at http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf
[7] CA Cost Benefit Analysis Worksheet in Appendix

programs continue to have an effect in reducing a range of problems including substance abuse and violence. However, the net returns are often only fully realized over the long-term (for actual longitudinal cost-benefit results see Karoly, et al., 1998; Schweinhart, et al., 1993).

Estimates of Prevention Need

As the data shows, substance use starts young (<14), increases exponentially throughout the middle and high school years, and peaks among young adults (18-25). The 2007-08 California Student Survey shows 2/3 of all 11th graders report lifetime use of alcohol and 42 percent drank in the past 30 days, with 29 percent reporting binge drinking. Twenty-four percent report use of marijuana within the past 30 days and 42 percent report lifetime use. The emerging documentation of the non-medical use of prescription drugs (18 percent report lifetime use) and over-the-counter medicines (35 percent report lifetime use of any pill or medicine) raise new concerns about the immediate and long-term consequences of substance use.

The number of Californian's in need of prevention is large. The first large group is adolescent and young adults. As the Table below displays, there are 5.3 million youth 12-20 years of age, and over 3 million of them have used alcohol or other drugs. Both broad substance problems - underage drinking, and use of illicit substances – are illegal for youth under 21 years of age. In addition non-medical use of prescription and over the counter (OTC) drugs among underage youth is harmful and carries with it high risk of adverse consequences. Thus the need to prevent youth from ever starting to use and to reduce their level of use to prevent the full range of immediate and long-term consequences from AOD use is extremely high.

California Youth Population Ages 12-20 in Need of Prevention

Age	CA Population Estimates 2010[a]	Estimated Percent of Students' AOD Use	Estimated Total Number of Students' AOD Use
12	527,182	29%	310,856
13	544,735		
14	569,432	60%	692,947
15	585,479		
16	596,384	74%	891,537
17	608,396		
18	624,345	53%	1,891,298
19	639,817		
20	627,136		
Total	**5,322,906**		**3,093,691**

Note. Data was retrieved from both the California Student Survey (CSS) and Behavioral Risk Factor Surveillance System (BFRSS), specifically CSS includes youth ages 12-17, and BRFSS includes 18-20 year olds. For CSS, 7th graders were 12-13 years old, 9th graders were 14-15 years old, and 11th graders were 16-17 years old. CSS assesses students' AOD lifetime use, and BRFSS assesses students' AOD use in the past 30 days

[a]Source: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050.* Sacramento, CA, July 2007

Over 3 million youth ages 12 – 20 are in need of *Universal* prevention strategies.

In addition, according to the CSS, 33 percent of 11th graders are classified as High Risk and/or Excessive Alcohol Users. This translated to approximately 300,000 16-17 year olds. This group will require more *selective and indicated* prevention interventions, such as Student Assistance Programs.

There are a number of other effective prevention and early intervention strategies to address preventing underage and reducing excessive consumption of alcohol and other drugs.[8] They include efforts to reduce availability of alcohol and other drugs, delay or reduce the consumption, change the social norms toward underage substance use, adult excessive consumption and abuse of illegal drugs, and reduce harm from the (excessive) consumption of these substances.

Evidence-based interventions often cover different aspects of the problem (e.g., youth drug use initiation, impaired driving, or violence), which make the use of complementary set of interventions more likely to be beneficial. Several interventions are best directed toward different aspects of the problem.

EARLY INTERVENTION

Reduction in Harm and Negative Consequences

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated public health approach to the delivery of early intervention to individuals at risk for developing substance abuse disorders. It is an effective intervention designed to intervene at the first signs of adverse consequences and reduce the harm and likelihood of future harm. The goal of SBIRT is to reduce the risks and consequences related to alcohol and other drug use consumption, to eliminate high-risk AOD use, and to increase motivation for behavioral change, up to and including referral to specialized AOD treatment services. It has been shown to reduce consumption among at risk AOD users and produce health care cost savings.

Estimates of Early Intervention Need

Other large groups in need of prevention/early intervention services are the young adult and adult groups who drink and use other drugs in risky and excessive ways. In nearly all categories of substances, young adults age 18-25 display the highest use patterns

[8] For example PIRE Report cited earlier; Effectiveness of Behavioral Highway Safety Countermeasures. National Cooperative Highway Research Program Report # 622, WASHINGTON, D.C., 2008.

and harms related to risky and excessive use (i.e., binge drinking, illicit substance use, poly drug use, heavy use). This age group represents 4.6 million of the California population. For example, 38 percent of this age group engages in binge drinking and 13.8 percent report having driven under the influence of alcohol, according to the 2007-08 NSDUH surveys. This suggests that between 635,000 and 1.75 million young adults within this age group could benefit from early intervention services (such as SBIRT) and that the harms related to their risky drinking could be reduced substantially.

In addition, there are many times as many young adults and adults who have alcohol or other drug problems than there are people who meet the diagnosis of abuse or dependence. Given that these more moderate users often contribute a larger portion of the public health consequences (e.g., DUI convictions, college drinking problems), there is a major need to address this large population of moderate and lower risk users also. However, little attention has been paid to this group of individuals who use and potentially abuse substances, but are not, or not yet, dependent.

Taken as a whole, the benefits of substance abuse prevention and early intervention well outweigh the costs of providing that service. Cost-benefit ratios can guide the selection of an optimal intervention package within the available resources. Political feasibility, cultural and demographic differences, and local priorities also must be considered.

In summary, the author's of the PIRE report conclude: "The cost of substance abuse could be offset by a nationwide implementation of effective prevention policies and programs.….Communities should consider a comprehensive prevention strategy based on their unique needs and characteristics and use cost-benefit ratios to help guide their decisions. Model programs should include data on costs and estimated cost-benefit ratios to help guide prevention planning."

TREATMENT

Estimates of AOD Treatment Need

A variety of methods were used to estimate the population in need of AOD treatment services. Some methods use a national standard to define treatment need while others use AOD prevalence rates as a proxy for needing treatment. Using prevalence estimates alone tend to overestimate those in need of treatment since not all persons who use alcohol or other drugs meet abuse or dependence criteria.

The first sections of the treatment need (overall, age, gender, and race/ethnicity) use estimates from the National Survey on Drug Use and Health (NSDUH). NSDUH data comes from self-report surveys produced by the Office of Applied Studies (OAS) of the SAMHSA. Data on 70,000 randomly selected individuals, 12 years and older, are collected annually, and the survey provides national and state level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use.

In NSDUH, all persons meeting criteria for alcohol and/or illicit drug dependence/abuse are counted as needing treatment. All those meeting these criteria who are not in

treatment are then counted as needing but not receiving treatment. The majority (95.2 percent) of persons who meet the criteria for needing treatment do not receive it because they do not feel they need treatment. State specific percentages were only available for the overall and age categories using data from the combined 2006 and 2007 surveys. The California estimates of those needing but not receiving treatment for either illicit drug use or alcohol use were derived by summing the individual percentages (i.e. percentage needing but not receiving treatment for illicit drug use plus the percentage of needing but not receiving treatment for alcohol use). This results in the estimate being high because the sum of the percentages do not account for persons that abuse both alcohol and other drugs. NSDUH does not provide a combined California percentage to eliminate this overlap. National percentages were used to estimate the number of individuals needing but not receiving treatment by gender and race/ethnicity using 2008 survey data. These estimates use the combined percentage of either illicit drug or alcohol use.

Because the above methodology does not allow breakouts of special populations, the special populations sections describe various studies that show the prevalence of AOD use and abuse among these groups. Studies specific to Californians are presented where available. The results of national studies are cited when no California specific data is available. Although these studies do not specially address treatment need, they provide valuable insight to describe patterns of AOD use among these subpopulations. Additionally, treatment data from ADP funded and/or licensed providers are presented to show the impact of these populations to the treatment system.

Overall

To estimate the number of all Californians 12 years and older who need but did not receive AOD treatment, the California population 12 years of age and older was multiplied by the sum of the percentage needing but not receiving treatment for illicit drug use and the percentage needing but not receiving treatment for alcohol use (both provided by NSDUH).

Needing but Not Receiving Treatment

2009 CA Population (age 12+)	Percentage Needing Tx for Illicit Drug Use (age 12+)	Percentage Needing Tx for Alcohol Use (age 12+)	Percentage Needing Tx for either Illicit Drug or Alcohol Use[a] (age 12+)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 12+)
32,193,265	2.57	7.8	10.37	3,338,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

[a]This percentage is derived by adding the percentage needing but not receiving alcohol treatment to the percentage needing but not receiving illicit drug treatment. This sum overestimates the percentage needing alcohol or other

illicit drug treatment because it doe not account for persons that meet both alcohol and drug abuse/dependence criteria. California specific estimates that account for this overlap are not available.

Highlights

- Over 3.3 million Californians are estimated to need, but are not receiving AOD treatment.

Age

The California population was categorized by the same age groups as those in the NSDUH survey. To estimate the number of Californians who need but did not receive treatment, the California population age groups were multiplied by the sum of the rates of needing but not receiving treatment for illicit drug use and the rates of needing but not receiving treatment for alcohol use (both provided by NSDUH).

Youth Age 12-17 Needing but Not Receiving Treatment

2009 CA Population (age 12-17)	Percentage Needing Tx for Illicit Drug Use (age 12-17)	Percentage Needing Tx for Alcohol Use (age 12-17)	Percentage Needing Tx for either Illicit Drug or Alcohol Use[a] (age 12-17)	Number Needing but Not Receiving Tx for Illicit Drug Or Alcohol Use (age 12-17)
3,497,305	4.19	5.55	9.74	341,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

Young Adults Age 18-25 Needing but Not Receiving Treatment

2009 CA Population (age 18-25)	Percentage Needing Tx for Illicit Drug Use (age 18-25)	Percentage Needing Tx for Alcohol Use (age 18-25)	Percentage Needing Tx for either Illicit Drug or Alcohol Use[a] (age 18-25)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 18-25)
4,598,102	7.07	16.8	23.87	1,098,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

Adults Age 26 and Over Needing but Not Receiving Treatment

2009 CA Population (age 26+)	Percentage Needing Tx for Illicit Drug Use (age 26+)	Percentage Needing Tx for Alcohol Use (age 26+)	Percentage Needing Tx for either Illicit Drug or Alcohol Use[a] (age 26+)	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol Use (age 26+)
24,097,858	1.48	6.43	7.91	1,906,000

Notes: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

[a]This percentage is derived by adding the percentage needing but not receiving alcohol treatment to the percentage needing but not receiving illicit drug treatment. This sum overestimates the percentage needing alcohol or other illicit drug treatment because it doe not account for persons that meet both alcohol and drug abuse/dependence criteria. California specific estimates that account for this overlap are not available.

Highlights

- Young adults 18-25 years of age have the highest, and youth age 12-17 have the lowest percentage needing but not receiving treatment for alcohol use.
- Young adults 18-25 years of age have the highest, and adults age 26 and over have the lowest percentage needing but not receiving treatment for illicit drug use.
- Overall young adults 18-25 years of age have the highest percentage needing but not receiving AOD treatment. They account for over one million people in need of treatment.
- Although the 26+ group has the lowest overall percentage needing treatment, it has the largest overall population. Therefore, this age group accounts for nearly two million people in need of treatment.

Gender

National estimates are used to determine the gender breakout of individuals in need but not receiving treatment. Percentages from the 2008 NSDUH were multiplied by the California population by gender.

Gender	2009 California Population (age 12+)	Percentage Needing but Not Receiving Tx for Illicit Drugs or Alcohol	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol[b]
Males	15,991,019	10.7	1,711,000
Females	16,202,246	6.1	988,000

Notes: Numbers Needing but Not Receiving Treatment are rounded to the nearest 1,000.

[b]These estimates of need are based on national estimates which account for the overlap in populations using both alcohol and illicit drugs. Additionally the percentage needing treatment for alcohol use is slightly lower for the nation than for California. Therefore the total number needing but not receiving treatment is lower than the number presented using California estimates..

Highlights

- Males have a higher percentage needing but not receiving treatment than females.

Race/Ethnicity

National estimates are used to determine the race/ethnic breakout of individuals in need but not receiving treatment. Percentages from the 2008 NSDUH were multiplied by the California population by race/ethnicity.

Race/Ethnicity	2009 California Population (age 12+)	Percentage Needing but Not Receiving Tx for Illicit Drug or Alcohol	Number Needing but Not Receiving Tx for Illicit Drug or Alcohol[b]
Hispanic	10,934,876	9.2	1,006,000
White	14,503,410	8.4	1,218,000
African American	1,927,834	8.2	158,000
American Indian	211,174	10.2	22,000
Pacific Islander	122,184	*	**
Asian	3,952,810	3.8	150,000
Multirace	540,977	9.1	49,000

*Low precision; no estimate reported.
** Unable to calculate.

Notes: Numbers Needing but Not Receiving Treatment are rounded to the nearest 1,000.

[b]These estimates of need are based on national estimates which account for the overlap in populations using both alcohol and illicit drugs. Additionally the percentage needing treatment for alcohol use is slightly lower for the nation than for California. Therefore the total number needing but not receiving treatment is lower than the number presented using California estimates..

Highlights

- American Indians have the highest percentage of needing but not receiving treatment for illicit drug or alcohol use.
- Hispanics have the next highest percentage of needing but not receiving treatment for illicit drug or alcohol use.
- Given their respective large percentages of the overall population, both Hispanics and Whites account for the largest proportions in need of treatment. Each group contributes over one million people to the estimate.

Summary of Population-based Estimates of Treatment Need

The information presented in the preceding sections estimates the number of individuals in need but not receiving AOD treatment by demographic characteristics. The NSDUH survey found only a small proportion of these individuals who need treatment actually sought treatment. Of the over three million Californian's over 12 years of age estimated to need but not receive treatment, about 4.8 percent or 160,000 felt they needed treatment, thus are more likely to seek treatment. The top three reasons for not seeking treatment are:

1. No Health Coverage/Could Not Afford Cost
2. Not Ready to Stop Using
3. Able to Handle Problem without Treatment

Survey respondents were allowed to list multiple reasons for not seeking treatment but these three reasons made up about 80 percent of them. Some of the other reasons mentioned include:

- No transportation/inconvenient
- No program having type of treatment
- Did not feel need for treatment at the time
- Did not know where to go for treatment
- Might cause neighbors/community to have negative opinion
- Might have negative effect on job.

Estimates of Treatment Need for Special Populations

NSDUH treatment need estimates are not available for the following special populations: pregnant women, older adults, homeless and veterans. Therefore, more general prevalence studies of these populations are used to estimate those in need of AOD treatment. Because these numbers may overlap to an unknown degree with the overall estimates provided above, their primary purpose is to highlight the need for treatment among the special populations. All of the following special population estimates use national level AOD prevalence information since California specific information is not available. The only exception is for estimates for pregnant women who use alcohol. For this estimate one of the four studies cited is California specific. We need better ways to identify the percentage of and reasons why these subpopulations do not seek treatment.

Pregnant Women

Drinking during pregnancy raises the risk of low-birth weight babies and intrauterine growth retardation, increasing the danger of infection, feeding difficulties, and long-term developmental problems. Heavy-drinking during the early months of pregnancy can result in the birth of babies with fetal alcohol syndrome.

The California Department of Public Health's birth records provide the number of pregnant women in California. It should be noted this data does not take into account those mothers who gave birth to multiple babies and those who had unsuccessful pregnancies/stillbirths.

The prevalence rate of alcohol use among pregnant women is from the Morbidity and Mortality Weekly Report, Alcohol Use Among Pregnant and Non-pregnant Women of Childbearing Age-United States, 1991-1995. The annual percentage of any alcohol use among pregnant women was 12.2 percent.

The prevalence rate of alcohol use was multiplied by the number of California women who gave birth in 2008 to determine the number of women who used alcohol during their pregnancy.

Number of CA Women who Gave Birth 2008	Rate of Alcohol Use	Number of Pregnant Women who Used Alcohol
551,567	12.2	67,000

Note: Number of pregnant women who used alcohol is rounded to the nearest 1,000.

The prevalence rate of drug use among pregnant women was obtained from ADP's Perinatal Environmental Scan Summary Report prepared by Children and Family Futures, Inc. This report cites four studies with prevalence rates for drug use during pregnancy ranging from 3.5 percent to 11 percent. For this report, the mean rate, 7.2 percent was used to estimate the number of pregnant women who used drugs.

Number of CA Women who Gave Birth 2008	Rate of Drug Use	Number of Pregnant Women who Used Drugs
551,567	7.2	40,000

Note: Number of pregnant women who used drugs is rounded to the nearest 1,000.

The total number of pregnant women who need AOD treatment was estimated by adding the number of pregnant women who used alcohol to the number who used drugs. This method doesn't account for the overlap of pregnant women who use both alcohol and other drugs, but provides a reasonable estimate in the absence of information on the overlap of use of alcohol and illicit drugs in this population.

Number of Pregnant Women who Used Alcohol	Number of Pregnant Women who Used Drugs	Pregnant Women Needing AOD Treatment
67,000	40,000	107,000

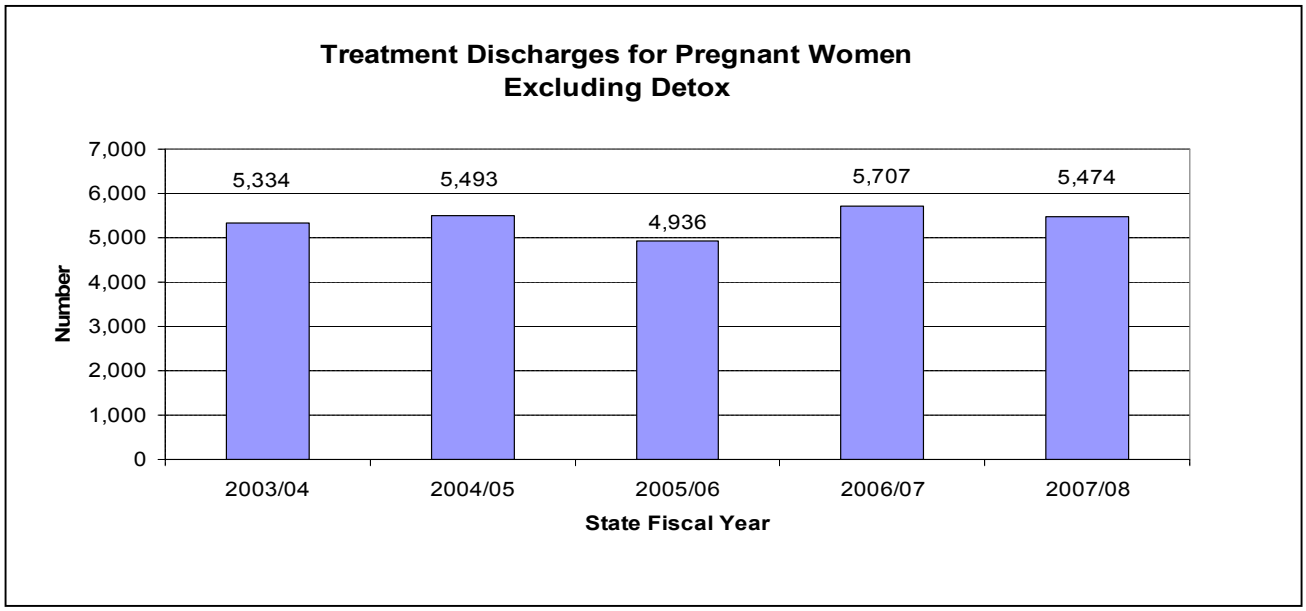
Note: Number of pregnant women who need treatment is rounded to the nearest 1,000.

Highlights

- Approximately 107,000 pregnant women in California used alcohol and/or drugs during pregnancy.

There is no available estimate on the percentage of those needing treatment who actually seek it for this specific subpopulation, therefore, the overall population estimate generated from NSDUH that documented about 4.8% of all individuals who need treatment seek it was used for the calculation.

The following chart shows the number of pregnant women discharged from AOD treatment (excluding detoxification) for the last 5 years by ADP funded/licensed facilities. This includes women who were pregnant at admission or anytime during the treatment stay. There were 5,474 treatment discharges (excluding detoxification) in SFY 2007/08 for pregnant women.



Older Adults

The proportion of older Californians is expected to grow substantially over the next few decades. Substance abuse in older adults 60 years of age and older is frequently an invisible problem. SAMHSA's Treatment Improvement Protocol (TIP26) reports that up to 17 percent of older adults misuse alcohol and prescription drugs. Multiplying California's population 60 and older by this prevalence rate provides an estimate of those needing AOD treatment.

2009 CA Population (age 60+)	Rate of Alcohol and Prescription Drug Misuse (age 60+)	Number Needing Treatment (age 60+)
6,143,524	17.0	1,044,000

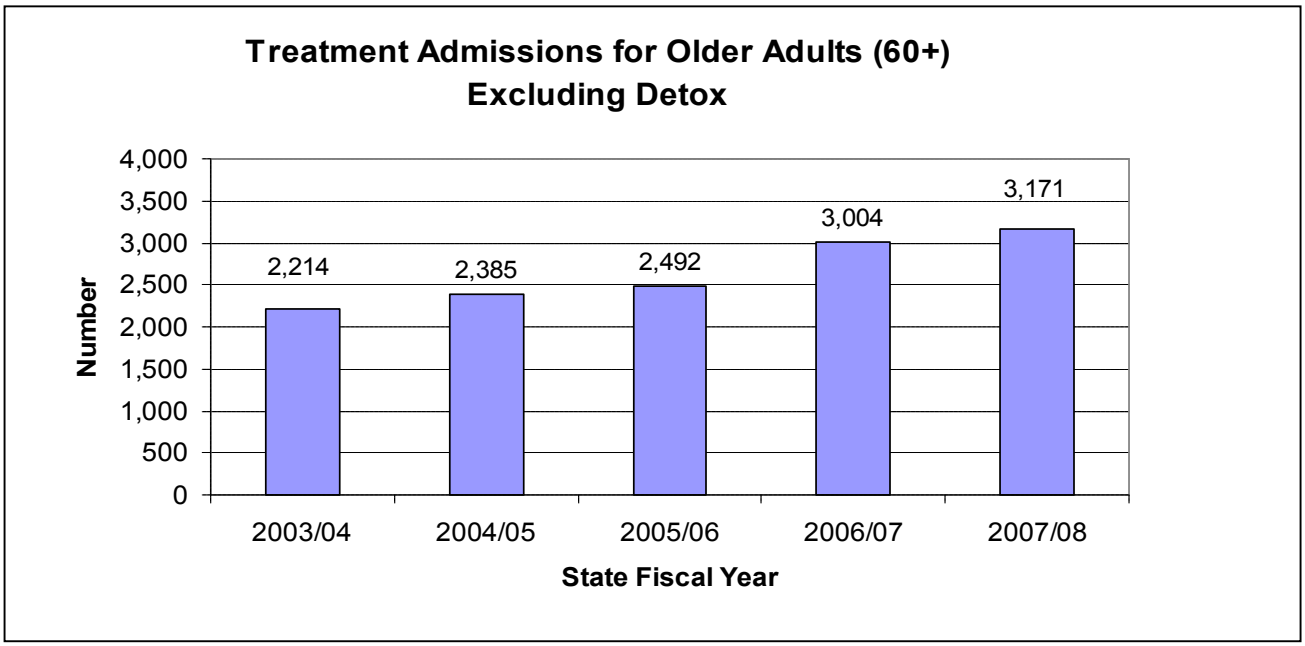
Note: Number needing treatment is rounded to the nearest 1,000.

Highlights

- Over one million older adults (60+) in California need services to prevent and treat drug misuse and abuse problems.

Once again, there is no available estimate on the percentage of those needing treatment who actually seek it for this specific subpopulation, therefore, the overall population estimate generated from NSDUH that documented about 4.8% of all individuals who need treatment seek it was used for the calculation.

The following chart shows publicly-funded/licensed treatment admissions for older adults during the past 5 years. The number of older adults receiving AOD treatment increased 43% from SFY2003/04 to SFY 2007/08.



For this population, the estimate of service need is based on information on misuse of alcohol and other drugs. Therefore, this estimate does not meet the criteria for needing AOD abuse or dependence treatment. Not all of the service need estimate is for AOD treatment. Reducing and treating drug use problems will require an integrated system of care that combines prevention, medical and behavioral health services to fully address the spectrum of AOD use related problems among the growing elderly population.

Homeless

Although obtaining an accurate, recent count is difficult, the Substance Abuse and Mental Health Services Administration (2003) estimates, 38 percent of homeless people were dependent on alcohol and 26 percent abused other drugs. Alcohol abuse is more common in older generations, while drug abuse is more common in homeless youth and young adults (Didenko and Pankratz, 2007). Substance abuse is much more common among homeless people than in the general population.

The homeless population is difficult to estimate since it constantly fluctuates and a variety of methodologies are used by different agencies using various definitions of homelessness. For the purposes of this report, the number of homeless in California for 2007 was obtained from the National Alliance to End Homelessness' website. This number is a point in time (one day) estimate of 159,732.

2007 CA Homeless Population	Prevalence Rate of Alcohol Abuse among the Homeless	Prevalence Rate of Drug Abuse among the Homeless	Combined AOD Abuse Prevalence	One Day Count of Number of Homeless Needing AOD Tx
159,732	38%	26%	64%	102,000

Note: Number needing treatment is rounded to the nearest 1,000

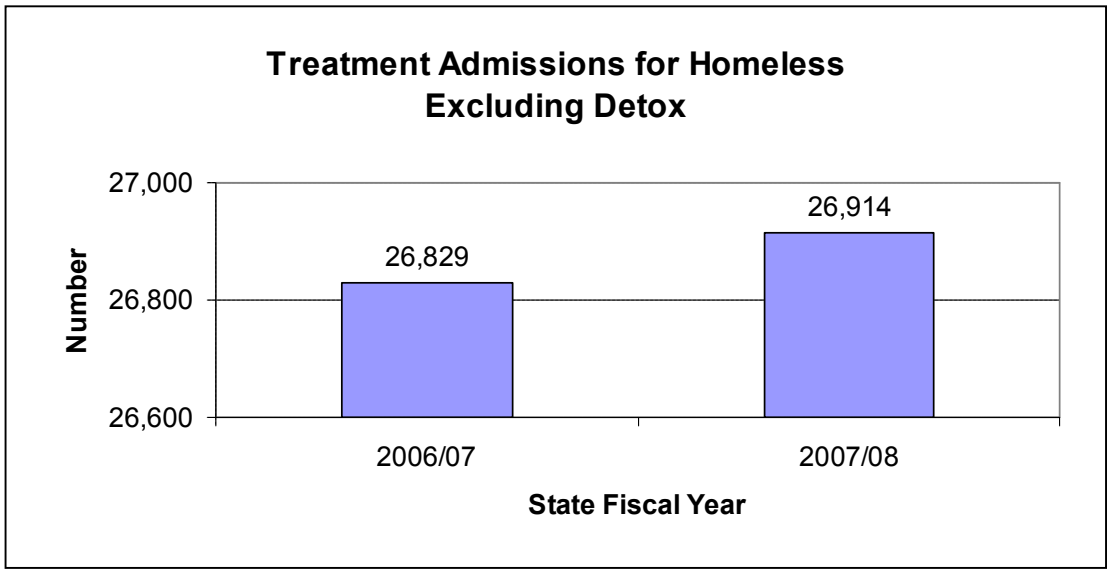
This method doesn't account for the overlap of homeless who use both alcohol and other drugs, but provides a reasonable estimate in the absence of information on the overlap of use of alcohol and illicit drugs in this population.

Highlights

- Over 100,000 California are homeless and in need of AOD treatment on any given day. This estimate varies from those for the other special populations in that it is a one day estimate rather than an annual estimate.

Once again, the 4.8% overall population estimate generated from NSDUH is used to estimate the percentage of this subpopulation in need of treatment who actually seek it, because there is no available estimate for this specific subpopulation.

Homelessness was collected as an optional data item on CADDS; therefore the data does not show a reliable representation of the treatment population and is not shown here. Two years of CalOMS treatment data is shown in the chart below.



Veterans

The number of veterans in California was obtained from the 2007 American Community Survey. This survey uses set standard age groups for veterans. The group "Age 18 and over" was used for this analysis.

The U.S. Department of Veterans Affairs estimated that one fifth (20 percent) of veterans had a substance use disorder between 2001 and 2005.
The number of veterans in need of treatment is estimated by multiplying the number of California vets by the percentage estimated to have a substance abuse disorder.

2007 CA Veteran Population (Age 18 and older)	Percentage with Substance Abuse Disorder	Number Needing Substance Abuse Treatment
2,079,606	20%	416,000

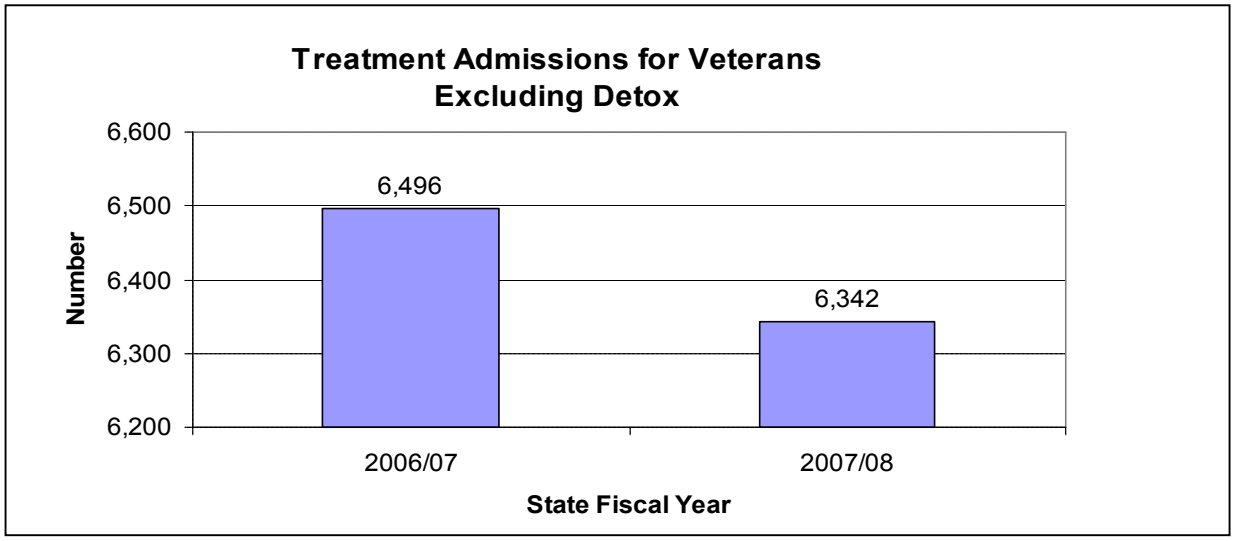
Note: Number needing treatment is rounded to the nearest 1,000

Highlights

- Approximately 416,000 veterans in California need AOD treatment.

Once again, the 4.8% overall population estimate generated from NSDUH is used to estimate the percentage of this subpopulation in need of treatment who actually seek it, because there is no available estimate for this specific subpopulation.

Many veterans have health benefits which cover treatment for substance abuse problems. Veterans who receive services from facilities that are run by the Department of Veterans Affairs or other facilities who are not required to submit data to ADP are not counted in ADP's treatment system. Information on veteran's status is collected in the CalOMS treatment data system but was not collected in CADDS. Therefore, only two years of treatment data is shown in the chart below.



Co-Occurring Disorders

The National Survey on Drug Use and Health (NSDUH) includes questions for adults aged 18 or older to assess serious mental illness (SMI) during the year prior to the survey interview. SMI is defined for the NSDUH report as having had at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and resulted in functional impairment that substantially interfered with or limited one or more major life activities.

Co-occurring disorders (COD) refers to a combination of at least one SMI and at least one substance abuse disorder. NSDUH found that during 2002 about eight percent of all adults had a SMI in the past year, and that about 23 percent of these persons also were dependent on or abused alcohol and/or an illicit drug. NSDUH also found that 52 percent of adults with co-occurring SMI and a substance use disorder received neither mental health nor specialty substance use treatment during the past year.

Given these NSDUH findings the following California estimates are provided of adults with co-occurring disorders and those who need treatment:

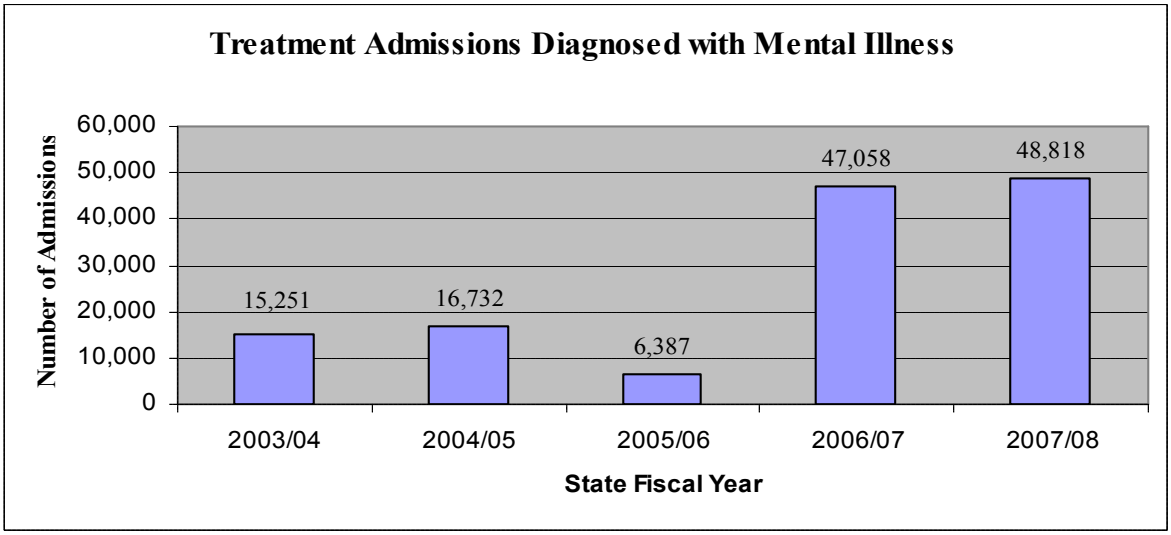
2009 CA Adult Population	Prevalence Rate of Co-occurring Disorders (8 % x 23 %)	Number of Adults with Co-occurring Disorders	Percentage of Co-occurring Not Receiving Mental Health or AOD Treatment	Number of Adults with Co-Occurring Disorders Needing Substance Abuse Treatment
28,695,960	1.8%	528,000	52%	275,000

Note: Numbers with co-occurring disorders and needing treatment are rounded to the nearest 1,000

Highlights

- There are approximately 275,000 adults in California with serious mental illnesses that also need AOD treatment.

Diagnosed with mental illness moved from an optional data collection question in the CADDS Tx data system (2003/04 - 2005/06) to a required data collection question in the CalOMS Tx data system (2006/07 – 2007/08), which likely accounts for the increase in incidence. Treatment admissions diagnosed with mental illness is fairly stable with a slight increase of 47,058 to 48,818 over the two years of required reporting. Because treatment admissions diagnosed with mental illness data is based on client self reporting; due to the nature of mental health issues it is believed that this data is under-reported.



Intravenous Drug Users (IDU)

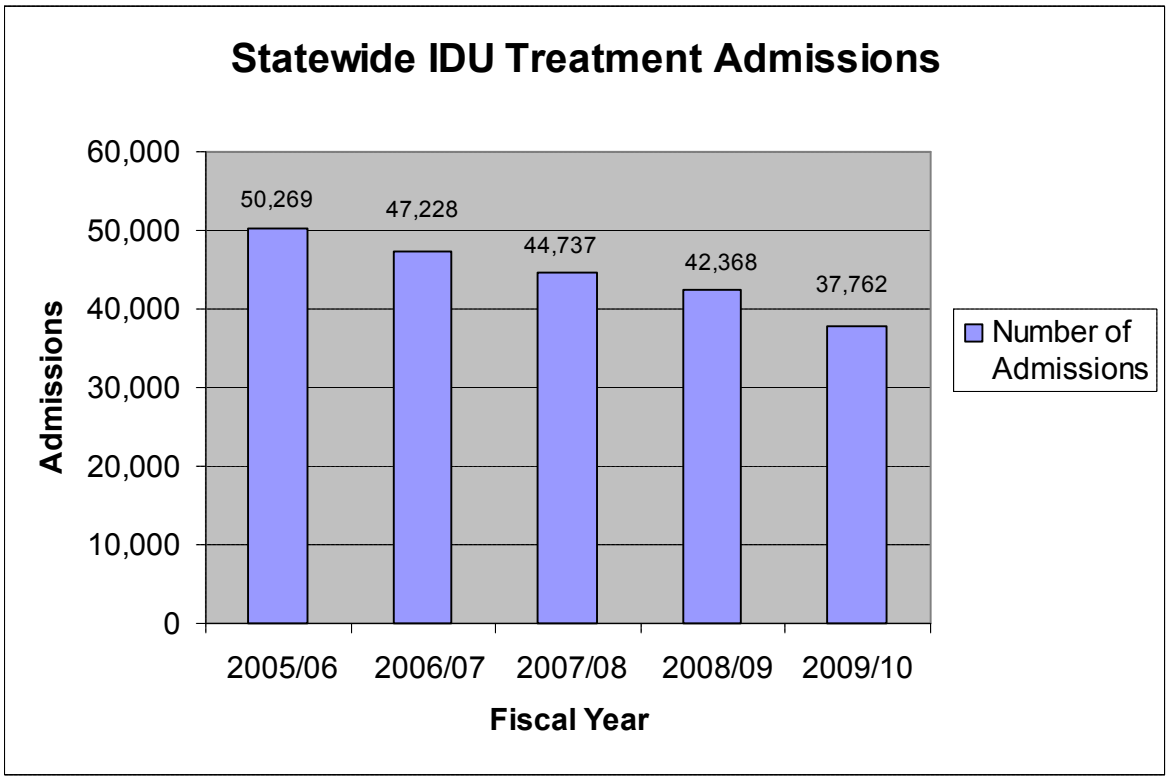
A data source was not located to obtain California demographic or California Census population data for IDU individuals nor was a source identified for prevalence rates of ID use. This is a data resource gap and an area in which technical assistance is needed to determine a methodology that will produce a reasonable estimate of IDU need. Absent the necessary data to determine IDU need, the following CalOMS Tx trend data is presented to get a picture of IDU in the publicly-funded treatment system.

CADDS/CalOMS Treatment (Tx)-Needle use by year

IV Drug Use (IDU) Admission Rates by Fiscal Year

Fiscal Years	IDU Tx Adm	Rate per 1,000 CA pop	Total Tx Admissions	Percent of Total
2005/06	50,269	1.65	225,776	22.26%
2006/07	47,228	1.53	222,163	21.26%
2007/08	44,737	1.43	222,327	20.12%
2008/09	42,368	1.33	217,856	19.45%
2009/10	37,762	1.17	187,492	20.14%

Note: Detoxification admissions are included; CADDS data for FY 2005-06; CalOMS data for FY 2006-07 through 2009-10



IDU Treatment -Length of Stay (LOS) by State Fiscal Year

Fiscal Years	IDU LOS <30 days	% of IDU < 30 Days	IDU LOS 30-59 days	% of IDU 30-59 Days	IDU LOS 60-89 Days	% of IDU 60-89 Days	IDU LOS ≥90 Days	% of IDU ≥90 days
2005/06	22,265	53.5%	4,633	11.1%	3,133	7.5%	11,576	27.8%
2006/07	20,431	62.1%	4,463	13.6%	2,800	8.5%	5,194	15.8%
2007/08	19,041	61.9%	4,239	13.8%	2,481	8.1%	4,995	16.2%
2008/09	18,408	61.0%	4,195	13.9%	2,535	8.4%	5,025	16.7%
2009/10	16,772	61.8%	3,831	14.1%	2,242	8.3%	4,296	15.8%

Note: CADDS data for FY 2005-06; CalOMS data for FY 2006-07 through 2009-10

IDU Percentage of Completed Treatment by State Fiscal Year

Fiscal Years	IDU Completed Tx	Percent of all Tx Discharges Completed	IDU Incomplete Tx	Percent All Tx Discharges Incomplete	Total IDU Tx Discharges
2005/06	11,483	27.6%	30,111	72.4%	41,594
2006/07	10,130	30.8%	22,758	69.2%	32,888
2007/08	9,286	30.2%	21,470	69.8%	30,756
2008/09	9,772	32.4%	20,391	67.6%	30,163
2009/10	8,562	31.5%	18,579	68.5%	27,141

Note: CADDS data for FY 2005-06; CalOMS data for FY 2006-07 through 2009-10

Highlights

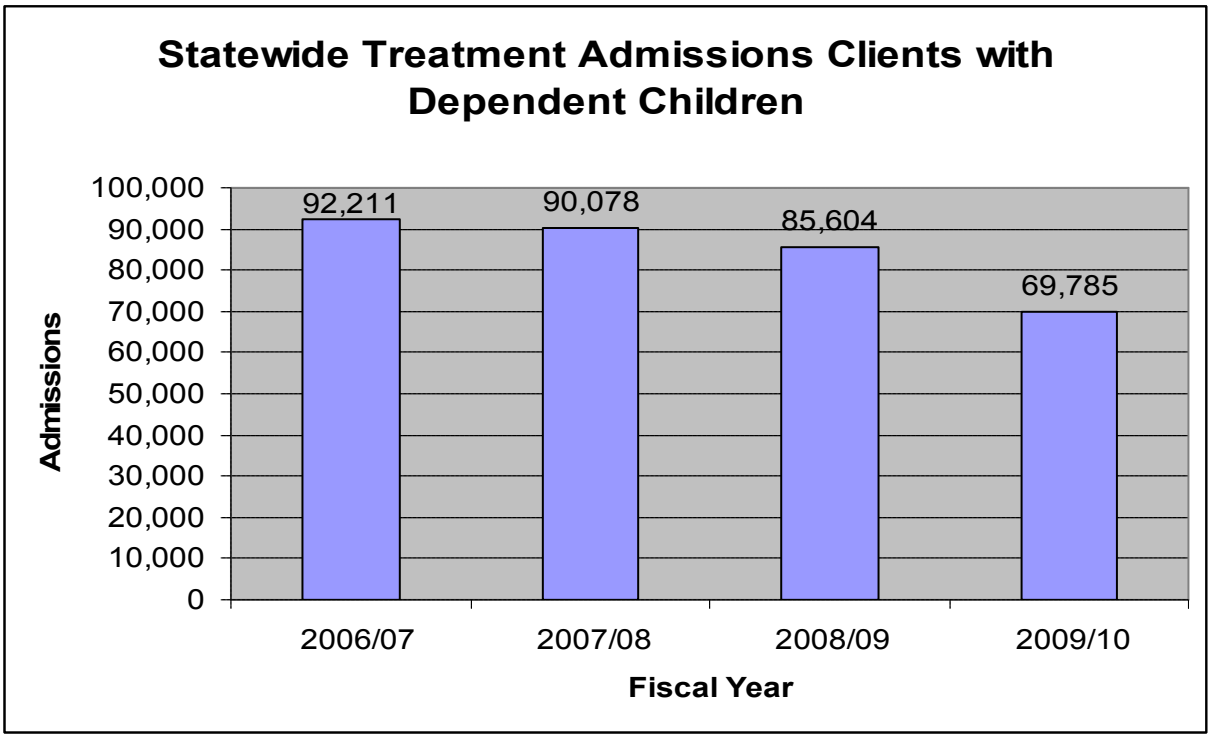
- The number of IDU treatment admissions declined over the five year period of time however, the percent of IDU admissions to overall admissions (while showing a slight decline) has remained relatively stable
- By far the highest percentage of treatment services for IDU were for < 30 days with the next highest being 90 days or more
- IDU completed treatment discharges represents less than a third of all IDU treatment discharges for all years

Parents who have Dependent Children

The following CalOMS data represents the four-year trend of treatment admissions for clients with dependent children. The data indicates a slight decline in admissions from year to year.

CalOMS-Tx Clients with Dependent Children[a]

Fiscal Year	Clients w/ Dependent Children Admissions	Rate per 1,000 CA pop	Total Tx Admissions	Percent of Total
2006/07	92,211	2.98	228,485	40.36%
2007/08	90,078	2.87	226,576	39.76%
2008/09	85,604	2.69	220,866	38.76%
2009/10	69,785	2.17	188,646	36.99%



Treatment Need

This section compares the demographic characteristics of persons needing but not receiving AOD treatment developed in the previous section with: a) California general population, and b) ADP's CalOMS treatment population.

For comparability each of these groups only include persons 12 years of age and older. The estimates of persons needing but not receiving treatment by age group are based on NSDUH data for California. However the estimates of persons needing but not receiving treatment by gender and race/ethnicity groups use national NSDUH data because California specific data was not available. The approximately three million Californians needing but not receiving treatment represents the number of potential new clients who are not currently receiving any AOD treatment services. However, NSDUH estimates that only 4.8 percent of these clients felt they needed treatment, and thus would likely seek it. Some of these clients may seek treatment in facilities under ADP's purview while others may seek treatment from other facilities.

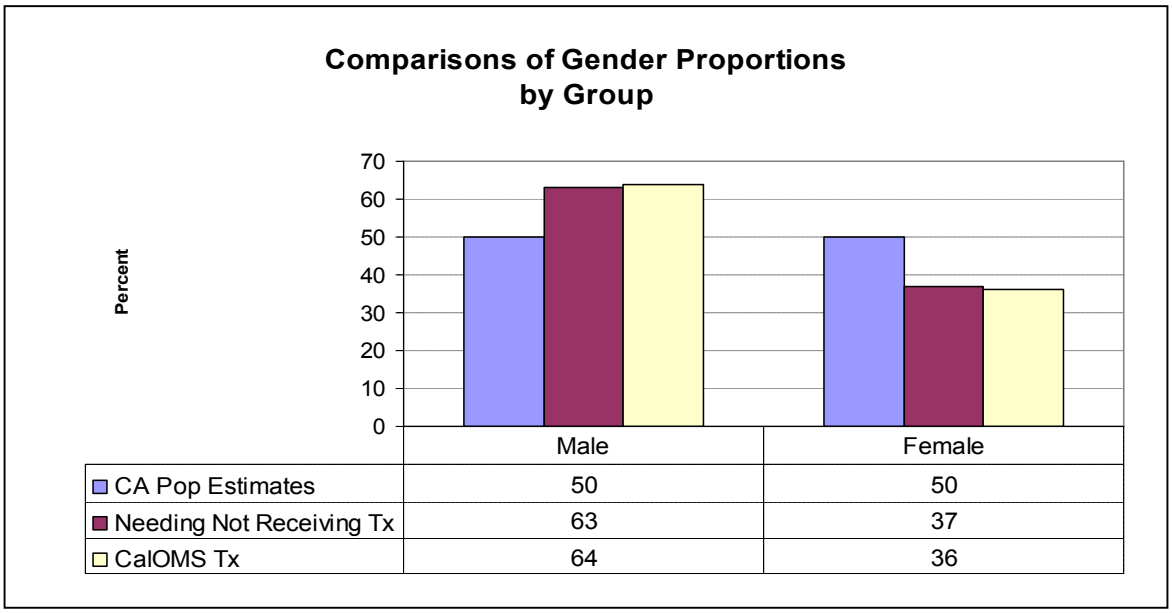
The California Department of Finance's Demographic Research Unit developed the California population estimates with demographic characteristics for 2009.

CalOMS collects data on clients that receive treatment services from ADP monitored and/or publicly-funded programs. The data represents unique clients served during SFY 07-08. The number of clients served is the sum of the number of new admissions and the number of clients admitted in a prior year but still receiving treatment services during SFY 07-08. CalOMS does not collect data from clients receiving services from tribal or

federal governmental entities or from many private, for-profit facilities. CalOMS clients typically include people of low socio-economic status (e.g. income, education, and occupation) and many are referred to treatment through the criminal justice system. Therefore, the characteristics of clients receiving treatment in CalOMS do not represent the characteristics of all clients in treatment.

Conclusions based on comparisons between these groups should not be made in isolation of other indicator data. Other data sources may reveal patterns within subgroups that are not shown using only NSDUH data. For example, it may not appear that African Americans overall need focused treatment efforts. However data from another source may indicate that African American youth have a particular high need for treatment services. Furthermore, barriers to treatment should be identified specific to subgroups so that services can be provided to those in greatest need of treatment services.

Gender



	Male	Female
CA Pop Estimates	50	50
Needing Not Receiving Tx	63	37
CalOMS Tx	64	36

Comparisons of Estimates Needing Not Receiving Treatment with the CA General Population shows that:

- NSDUH estimates a higher proportion of males need treatment than are represented in the general California population.
- Conversely, a lower proportion of females need treatment than the proportion found in the general California population.

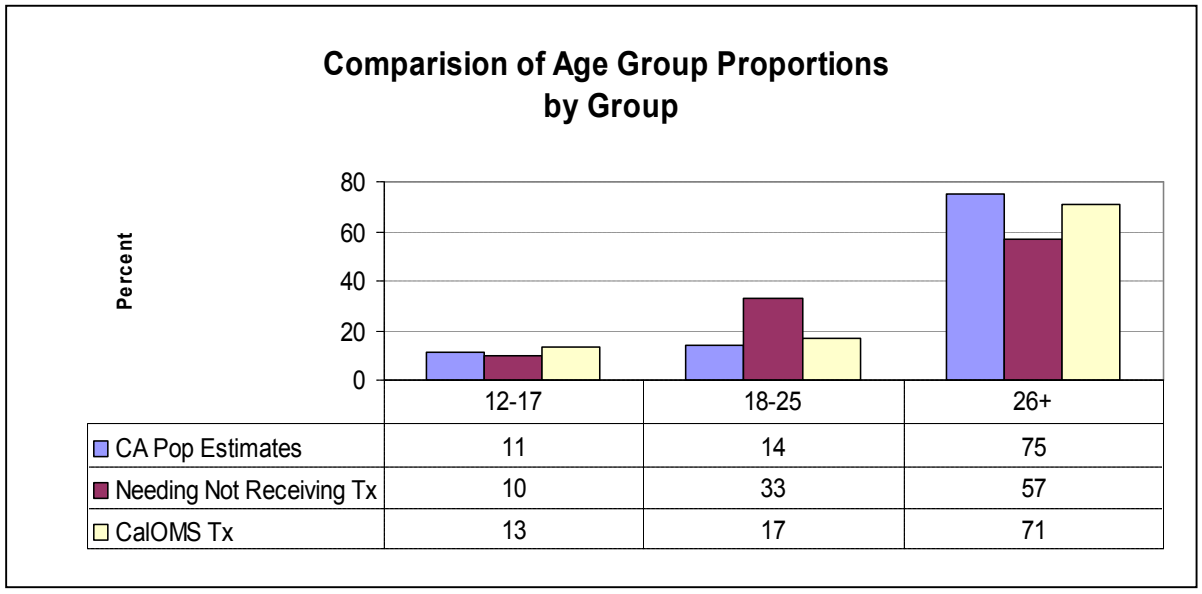
Comparisons of Estimates Needing Not Receiving Treatment with CalOMS Treatment Population shows that:

- The gender proportions in CalOMS are very similar to the proportions needing but not receiving treatment estimated by NSDUH.

Implications

- If the additional clients estimated by NSDUH to need treatment were to seek it, their gender proportions would be very similar to those already receiving treatment in ADP monitored/funded treatment programs. However, as previously mentioned the characteristics of the CalOMS clients do not represent the entire population who need AOD treatment.

Age Group



	12-17	18-25	26+
CA Pop Estimates	11	14	75
Needing Not Receiving Tx	10	33	57
CalOMS Tx	13	17	71

Comparisons of Estimates Needing Not Receiving Treatment with the CA General Population shows that:

- NSDUH estimates that lower proportions in the 12 through 17, and 26 and older age groups still need treatment, compared with their respective proportions of the general California population.
- NSDUH estimates that a higher proportion in the 18 through 25 age group still needs treatment compared with their proportion of the general California population.

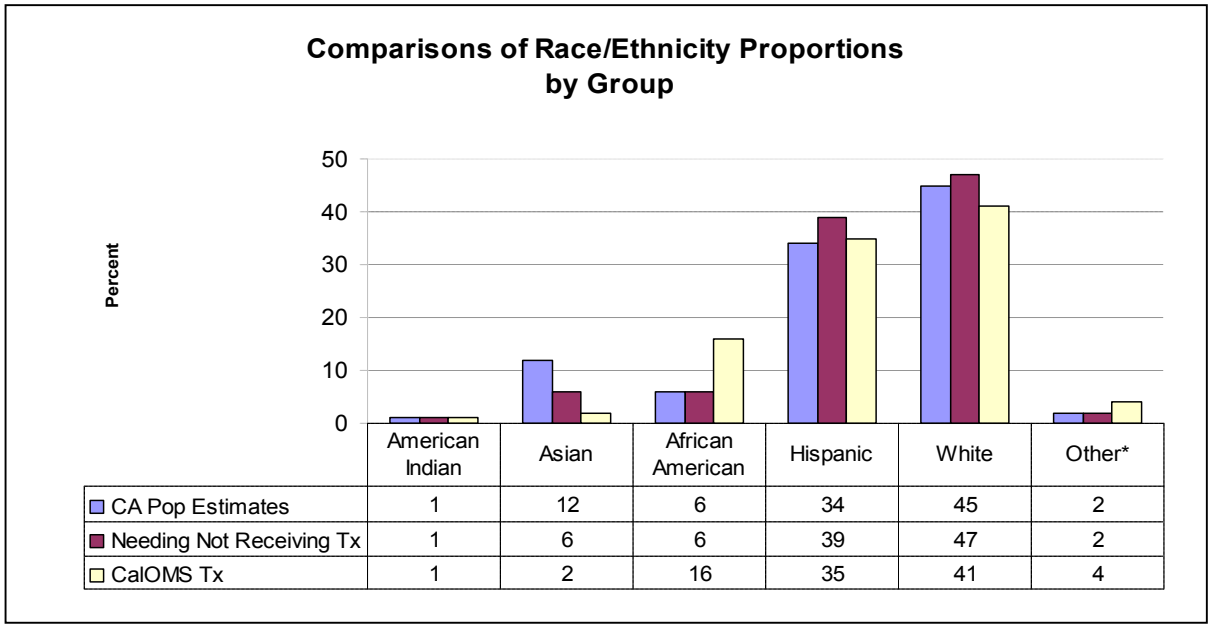
Comparisons of Estimates Needing Not Receiving Treatment with CalOMS Treatment Population shows that:

- Those in age groups 12 through 17, and 26 and older have higher percentages in treatment than their respective percentages of the total needing but not receiving treatment.
- Conversely, those in the 18 through 25 age group have a higher percentage needing but not receiving treatment than their respective percentage of the total in treatment.

Implications

- If the additional clients estimated by NSDUH to need treatment were to seek it, a larger proportion would be from the 18 through 25 year old age group than those already receiving treatment in ADP monitored/funded treatment programs. As previously mentioned, characteristics of CalOMS clients do not represent the entire population who need treatment in California. Also, the NSDUH estimates of treatment need are based on criteria of abuse and dependence that may surpass use patterns for the younger 12 though 17 age group. Therefore further investigation of those in the younger age groups whose use patterns that did not meet the dependence criteria may reveal a need for less intensive services including prevention, intervention and/or brief treatment.

Race/Ethnicity



	American Indian	Asian	African American	Hispanic	White	Other*
CA Pop Estimates	1	12	6	34	45	2
Needing Not Receiving Tx	1	6	6	39	47	2
CalOMS Tx	1	2	16	35	41	4

* Other includes Pacific Islanders and Multiple Race Groups

Comparisons of Estimates Needing Not Receiving Treatment with the CA General Population shows that:

- NSDUH estimates a higher need for treatment in the Hispanic and White populations than their proportions of the general California population.
- Asians, on the other hand, have less needing but not receiving treatment than their proportion of the general California population.
- American Indians, African American, and the "Other" race/ethnicity group, have percentages needing but not receiving treatment that are equal to their respective proportions of the general population.

Comparisons of Estimates Needing Not Receiving Treatment with CalOMS Treatment Population shows that:

- American Indians have equal percentages of the total in treatment, and needing treatment.
- Asians, Hispanics, and Whites have higher percentages needing but not receiving treatment compared with their respective percentage of the total in treatment.
- African Americans and the "Other" race/ethnicity group have higher percentages in treatment compared with their respective percentage of the total needing but not receiving treatment.

Implications

- If additional treatment was available, the NSDUH estimates show that certain race/ethnicities have higher proportions of their group needing treatment than others. In particular, Asians, Hispanics and Whites have higher percentages needing treatment than are currently being treated in publicly monitored treatment. However, as previously mentioned, the characteristics of CalOMS clients do not represent the entire population who need treatment in California. Additional data sources should be examined to determine specific treatment needs and barriers (e.g., socioeconomic, language, transportation) to treatment among the various race/ethnic subpopulations.

Recovery Support Services Need

Evidence has shown that providing Recovery Support Services (RSSs) results in increased effectiveness of services and reduced preventable re-admissions, which can help lower overall treatment costs and other societal consequences that arise from AOD disorders. Currently in California, RSS is mostly unfunded except for special grants and pilot projects. For COSSR to be fully realized, investments in RSS must be made in order to fully benefit from a continuum of services system. As health care reform is implemented nationwide, now is a logical time to reevaluate funding streams to ensure RSS is a funded component of the continuum.

Related Public Health Issues

HIV/AIDS and Substance Use

AIDS is a diagnosis associated with a set of symptoms and infections resulting from damage to the human immune system caused by a virus called the Human Immunodeficiency Virus (HIV).

Substance use increases ones risk for HIV transmission.[9] It is well known that injecting drug users (IDU) are at great risk for HIV infection when sharing equipment with other users. Infected blood can be drawn up into a syringe and then injected along with the drug into the next user of the syringe. However, HIV infection can happen even through small amounts of blood on cookers, filters, tourniquets, on hands, or in rinse water. In 2006, of the estimated new HIV infections nationwide, 12 percent were attributable to the

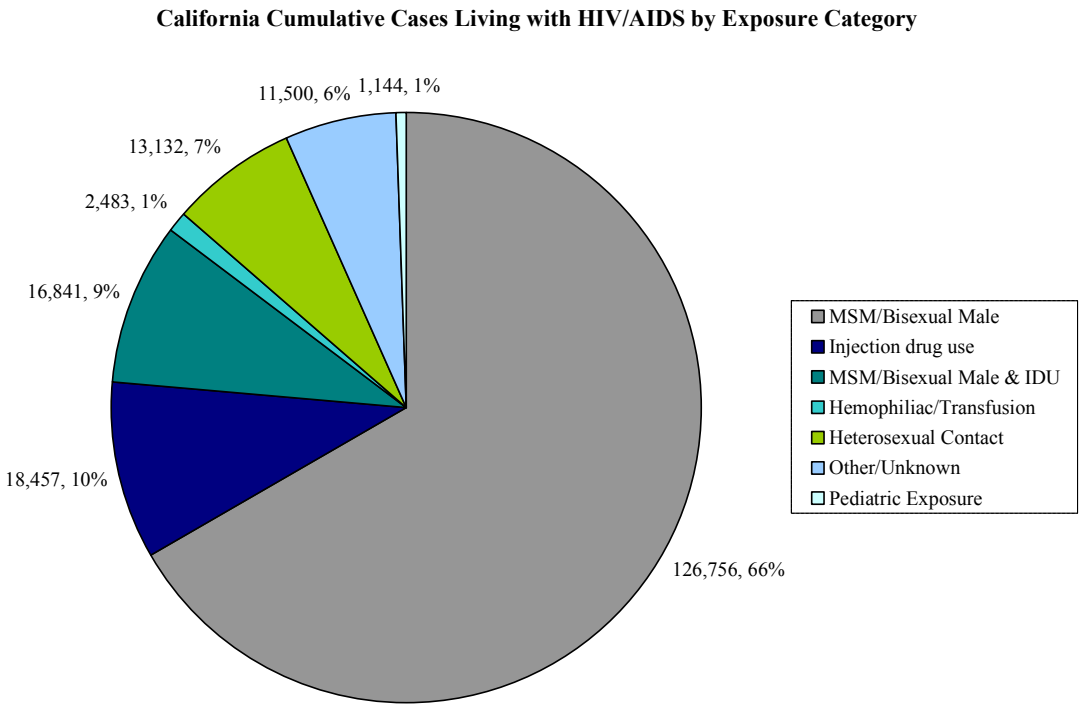
[9] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *HIV/AIDS.* Retrieve March 12, 2009, from http://www.dpt.samhsa.gov/comor/hivaids.aspx

IDU transmission mode. Those who reported both male-to-male sexual contact and IDU accounted for an additional four percent.[10] Less often discussed are the addictive and intoxicating effects of substance use which may increase the likelihood an individual participates in unsafe sexual behavior. HIV infection risk is further increased when substance use is combined with commercial sex for money/drugs, or sex with multiple partners.

HIV/AIDS in California

California originally started collecting AIDS case data in 1983. More recently HIV reporting has been included. HIV reporting began with non-name code in 2002 and evolved to HIV reporting by name in 2006.

The following pie chart shows the cumulative living HIV/AIDS cases by suspected mode of transmission. Since it is impossible to be certain how an individual was infected, the mode of exposure may include multiple transmission modes. For instance in the chart below there are categories for both IDU only and for men who have sex with men/bisexual in combination with IDU (MSM/Bi IDU).



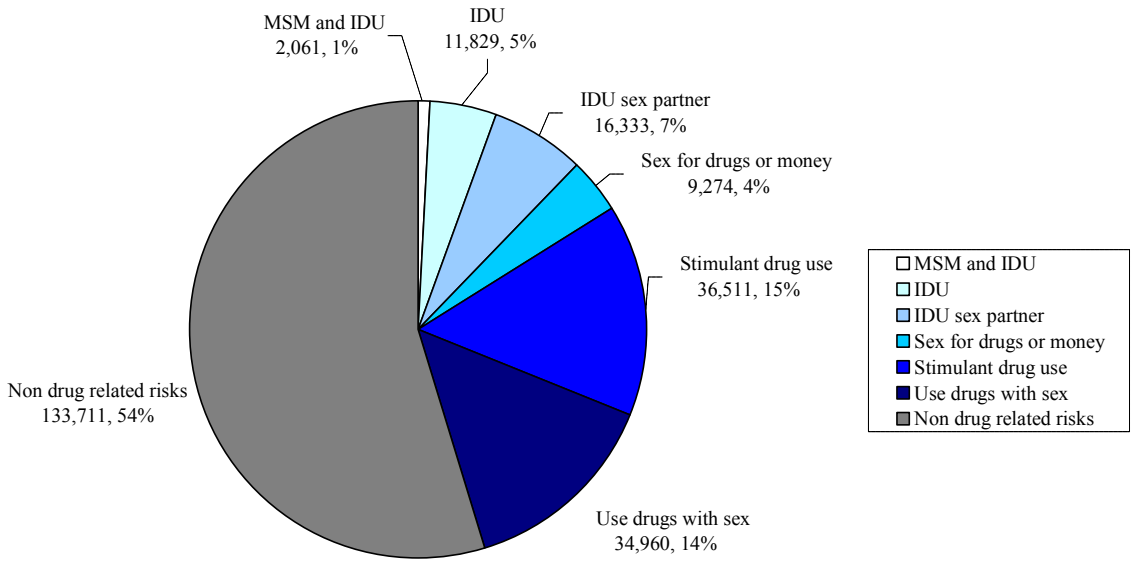
Source: California Department of Public Health, Office of AIDS, HIV/AIDS Case Registry Section, data as of April 30, 2009. HIV reporting began in April 2006; AIDS reporting began in March 1983.

[10] California Department of Justice, Criminal Justice Statistics Center. (2008). *Crime in California, 2008.* Sacramento, CA: http://ag.ca.gov/cjsc/pubs.php

As of April 30, 2009, IDU and MSM/Bi IDU mode of exposure accounts for 19 percent of all living HIV/AIDS cases reported in California which is higher than the national average.

Another data source available to help determine HIV prevalence and mode of exposure is California's publicly-funded HIV counseling and testing data. The following pie chart shows the self-disclosed risks of all individuals receiving publicly-funded HIV counseling and testing services in 2007.

Self Disclosed Risks Reported by Individuals Tested for HIV:
2007 California Publicly Funded HIV Counseling and Testing Data*

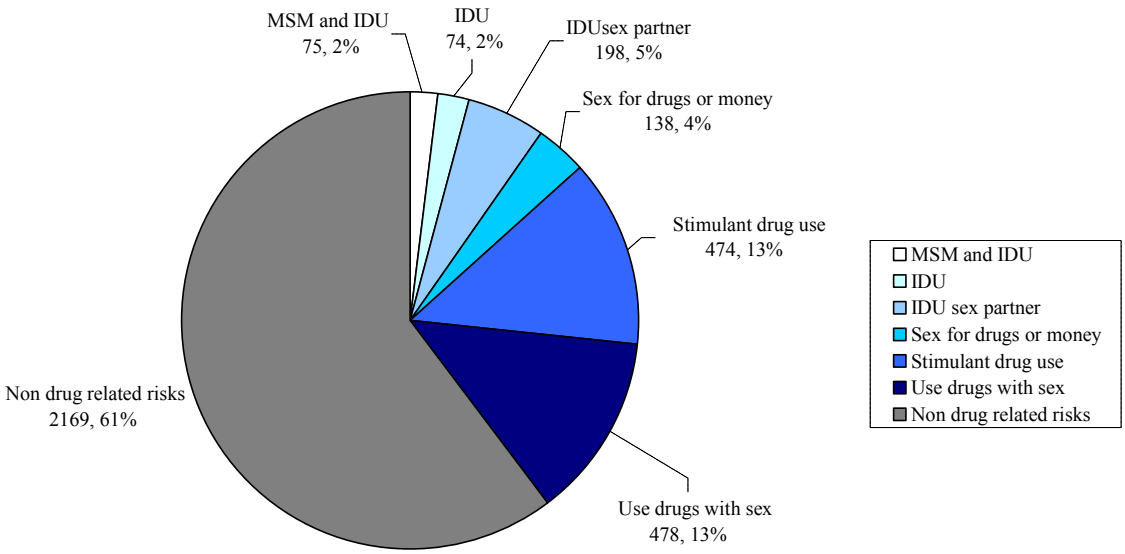


* Based on HIV C&T data received and processed as of November 13, 2008. Data may be incomplete.
Source: California Department of Public Health, Center of Infectious Diseases, Office of AIDS

The data show of all the self reported increased risk factors for HIV transmission **46 percent** were related to drug use.

The second pie chart illustrates, of those who tested positive, or indeterminate, the number that disclosed a drug-related risk.

Self Disclosed Risks Reported by Individuals that Tested HIV Positive:**
2007 California Publicly Funded HIV Counseling and Testing Data*



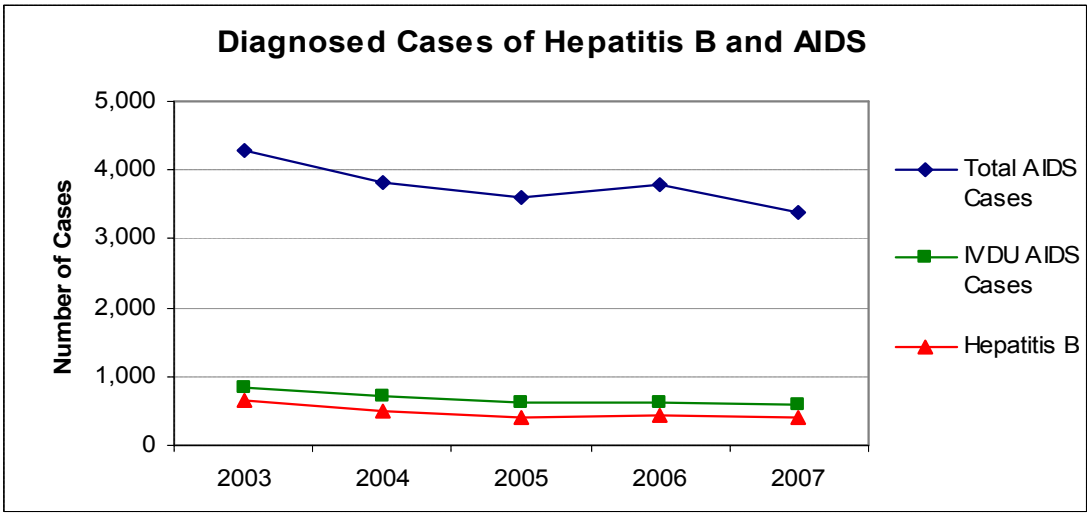
* Based on HIV C&T data received and processed as of November 13, 2008. Data may be incomplete.
** Indeterminate test result means additional testing is needed to rule out a false positive.
Source: California Department of Public Health, Center of Infectious Diseases, Office of AIDS

Of those that tested HIV positive or indeterminate, a 39 percent drug-related risk was reported. This data further illustrates the high correlation between substance use and HIV infection.

Diagnosed Cases of Hepatitis (Type B) and AIDS

Serum Hepatitis (Type B) is an inflammation of the liver, usually accompanied by fever and other systemic manifestations. The reporting physician makes a diagnosis of either Type A or B. Both homosexual males and users of illicit injectable drugs are among the groups acquiring the highest rate of Type B.

Intravenous drug users (IVDU) are at risk of HIV, (possibly leading to an AIDS diagnosis) and Hepatitis B infection, by sharing needles with infected persons. Non-intravenous drug users may acquire these diseases when they engage in risky behavior that they might not engage in while they are under the influence of alcohol or other drugs.



Tuberculosis (TB)

TB and Substance abuse

Substance abuse is the most common behavioral risk factor reported by patients with TB in the United States. Furthermore, due to delayed diagnosis, TB patients that report substance abuse are more contagious and remain contagious longer. This delayed diagnosis may be caused by decreased access to routine medical care. Patients that abuse substances are also less likely to begin and complete treatment for their TB. This is compounded by the fact that anti-tuberculosis medication is usually metabolized by the liver, which is often damaged by substance abuse.[11]

TB in California

In 2008, 2,695 TB cases were reported in California. Although this was the lowest ever reported, the rate of decline slowed from five percent a year declines in 2003-2006 to less than two percent in 2007 and only one percent in 2008. California accounted for 21 percent of all the TB cases in the United States in 2008 the most cases reported by a State in the nation. So, although the declining number of TB cases represents success in control and prevention efforts, TB continues to be a threat to California's public health.[12]

The table below shows that in 2008 nearly 18 percent of the 2,695 persons with TB reported substance abuse as a risk factor for their exposure to TB.

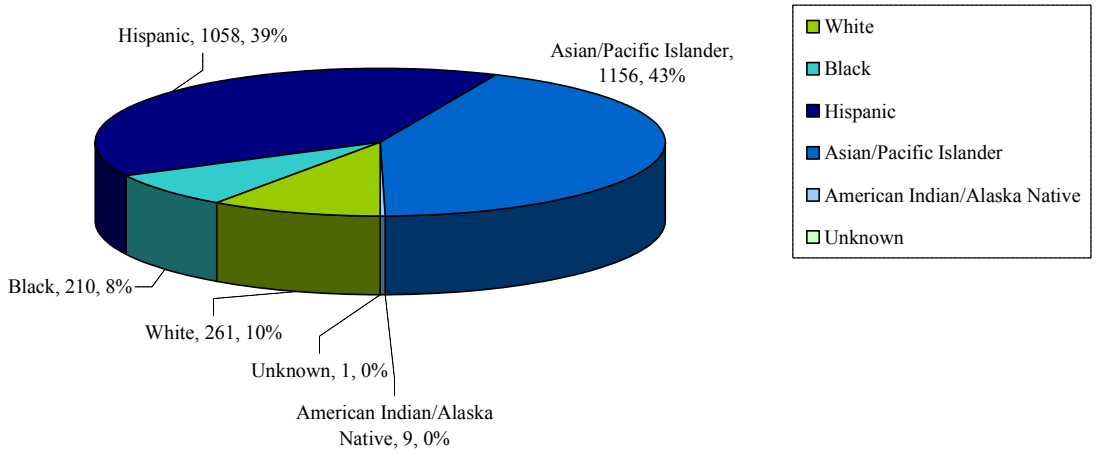
[11] Oeltmann et al. (2009). *Tuberculosis and Substance Abuse in the United States, 1997-2006*. Archives of Internal Medicine, 169 -189.
[12] California Department of Public Health. (2008). *Report on Tuberculosis in California, 2007*. Retrieved from www.cdph.ca.gov/data/statistics/documents/TB_Report_2007.pdf

Substance Abuse TB Risk Factors Reported: California 2008		
	Total Tested	
Self-disclosed Risks	#	%
Injecting Drug Use	37	1.4%
Non-injecting Drug Use	176	6.7%
Excess Alcohol Use	257	9.7%
Total Substance Abuse Risk Factors Reported	**470**	**17.8%**
Total TB Cases Reported	2,695	100 %

*Substance Abuse within the past 12 months
Source: California Department of Public Health, Tuberculosis Control Branch

The graph below shows TB cases in 2008 in California by race/ethnicity. Asian/Pacific Islander and Hispanic populations may be at particular risk for TB infection: these groups accounted for 82% of the TB cases in California in 2008.

Tuberculosis Cases by Race/Ethinicity: California 2008



Source: California Department of Public Health, Tuberculosis Control Branch

Another high risk group is individuals born outside the United States. They account for over 75 percent of the TB cases in California in 2008; however, substance use is still the most common behavioral risk factor. Another risk factors is homelessness.

Hepatitis C (HCV)

HCV and Substance Abuse

Hepatitis C viral (HCV) infection causes an estimated 8,000 to 10,000 deaths in the United States annually.[13] Individuals who abuse substances have an increased risk for HCV infection.[14] At 60 percent, Intravenous Drug Users are at the highest risk of HCV infection, but even non-injecting drug users are at an increased risk when compared to the general population. The general population rate of HCV infection is lower than two percent.[15] In a recent study of HCV, of those who reported a current or prior substance use disorder 26 percent tested positive for HCV. Of those that did not report a substance use disorder only five percent tested positive. Furthermore, 66 percent of those who tested positive reported a substance use disorder.[16] Unlike Hepatitis A and B, no vaccine exists against HCV. Prevention of HCV relies on identifying those at high risk for HCV infection and providing screening, testing, and counseling services to those individuals.[17]

HCV in California

Approximately 600,000 people in California—approximately two percent of the state's population are infected with HVC.[18] As discussed in the study, 66 percent of those who tested positive for HCV reported substance abuse as a risk factor; as many as 396,000 of the 600,000 Californian's infected with HCV are related to substance abuse.

[13] California Department of Public Health, Office of AIDS (2008). *Hepatitis Virus Co-infection*. Retrieved from http://ww2.cdph.ca.gov/programs/aids/Documents/FSHEPC2008-04.pdf

[14] National Digestive Diseases Information Clearinghouse. Chronic Hepatitis C: Current Disease Management. Retrieved March 25, 2009 from http://digestive.niddk.nih.gov/ddiseases/pubs/chronichepc/

[15] Hagedorn et. al. (2007). *Integrating hepatitis prevention services into a substance use disorder clinic*. Journal of Substance Abuse Treatment 32, 391-398.

[16] Huckans et. al. (2007). Interferon alpha therapy for hepatitis C: treatment completion and response rate among patients with substance use disorder. Substance Abuse Treatment, Prevention, and Policy, 2-4.

[17] Centers for Disease Control and Prevention. (March 21, 2008). *Surveillance for Acute Viral Hepatitis- United States, 2006*. Morbidity and Mortality Weekly Report, Vol. 57.

[18] Oeltmann et al. (2009). *Tuberculosis and Substance Abuse in the United States, 1997-2006*. Archives of Internal Medicine, 169 -189.

NEEDS ASSESSMENT FINDINGS AND DEVELOPMENT OF STATE PRIORITIES

As a part of the SNAP process, ADP's Executive Team along with all the County Alcohol and Drug Program Administrators provided input to determine the state's priority areas based on the following needs assessment findings. The findings are categorized as system findings, substance-based findings and specific population-based findings.

The AOD System Findings

Clearly California's publicly-funded AOD services system is moving in a direction that includes a fuller continuum of services, values scientifically supported practices, and promotes performance and data-informed planning and decision making. The vision for the system has been articulated, as has the expectation that cost efficiency and more effective services will be the outcomes.

The Continuum of Services

While many of the components of the system are in place, there is still a large capacity building effort required in order to realize all the benefits. Specifically, findings are:

- While prevention activities have been a component of the system for many years, the proliferation of evidence-based strategies and policies is not yet widespread throughout the system. As the data for youth shows, there is a large unmet prevention need. Employing more proven population-based strategies will be an effective method for impacting a large portion of the unmet need, therefore, reducing the future need for treatment and the resulting negative consequences.

  In addition, with the prevention emphasis related to health care, AOD prevention efforts become doubly important because prevention has become a key component of the health care model. New funding strategies and sources need to be identified in order to mirror that importance in the AOD system. When the "treatment" benefits from effective prevention efforts are examined as part of the system performance, then a re-evaluation of traditional funding priorities must also be considered and new funding sources identified.

- SBIRT as an early intervention strategy is showing promising results in California. Currently, operating as projects under one-time funding, sustainability of training efforts and creating widespread interest in partner service systems will be paramount to building statewide capacity to provide this intervention in the appropriate venues. In addition, establishing other prevention and early intervention strategies that delay onset and reduce harm will ensure a comprehensive statewide approach in making these services available.

- The prevention and treatment system in California has been working over the past several years, toward instituting evidenced-based practices, process improvements and performance measures to increase the effectiveness of treatment services. These efforts have been pursued not only as good business

practice but also due to the recognition that there are many more people in need of treatment services than the publicly-funded system can currently accommodate, so making the best use of limited resources becomes even more critical. Unfortunately, priority populations in the treatment system are often set by the specific funding source (i.e., IVDU, pregnant and parenting women, criminal justice). As a result of categorical funding approaches, the treatment system has not been set up to serve all individuals with substance use conditions that coincide with what the prevalence data indicates. As a matter of public policy, other factors (e.g., public health, public safety, cost offsets) have been used to determine who receives publicly-funded treatment services.

The treatment system path has been set and should continue focusing on increasing treatment effectiveness for those it serves as it continues to transition to a chronic disease model of treatment.

- Recovery support services are recognized as critical components of the continuum of services in California and need further development. Widespread capacity building will not be possible without a dedicated or allowable funding source.

- Performance measures and data-informed planning and decision making models continued to be implemented at the local and state level. These are not fully integrated throughout the system as of yet and are still being embedded within operations at the provider, county and state levels. Continuing in this direction will be important for the AOD system going forward.

Health Care Reform

The implementation of the major provisions of the PPACA in 2014, will mean substantial changes for the AOD system. The directions that the AOD system has been moving in over the last several years, however, will serve it well in transitioning to the new health care world. While there are many unknowns still related to the implementation of the PPACA that makes planning for the changes challenging, there are some known factors that should be used to spur planning activities.

Under the PPACA the primary health care system will be a major entry point for substance use screening, early intervention and treatment. As approximately 4.5 million more Californians obtain health care insurance, the potential to reach at least a portion of the 3.3 million currently in need of treatment, the 300,000 youth in need of early intervention, and the 3 million youth that could benefit from universal prevention strategies is huge. A primary health care system that is well educated on substance abuse will exponentially expand the capacity of the AOD system in California to prevent and treat substance abuse.

Since there will be varying levels of knowledge within that system, providing the primary care system with a toolkit of options and resources for educating, serving and/or

referring patients with identified or suspected substance abuse is a value added activity that should be considered.

Also, of the 4.5 million additional insureds, a conservative estimate is that close to two million of those will be insured through the public benefit, Medi-Cal in California. If 10 percent (the rate of those needing but not receiving treatment) of those, or approximately 200,000 need treatment, then the Medi-Cal authorization, billing and monitoring system capacity needs to be expanded, as well as an aligning of the current primary care Medi-Cal system and the Drug Medi-Cal system which currently operate separately. A thorough examination of the changes required to the Medi-Cal system must be undertaken to sort out the issues and ensure an efficient system with the capacity for expansion.

For the 2.3 million Californians who will remain uninsured, the publicly-funded AOD system of services can provide a safety net for those that are in need of services. Exploring and defining who this population is likely to be comprised of and projecting their AOD needs will be an essential component of the planning process.

A key component of making the transition to the new health care world will be a concerted workforce development effort to ensure that AOD staff have the qualifications necessary for insurance reimbursement and delivery of effective services and activities. Along with qualified staff, a proven record of performance will be required. The primary care world and insurers put a high value on “preventable readmissions” so effective services will be a requirement of the partnership between the primary care and AOD systems.

Finally, data collection and reporting must be further developed and refined in order to provide accurate estimates, describe relevant aspects of current clients (i.e., insurance status, parenting status, other public benefit status, matriculation through services), and project service use patterns for different levels of service need.

These are some fundamental steps that can be taken now:

- Develop a plan based on the “knowns” of health care reform and add to it as further information and details come to light.
- Consider how to partner and educate the primary care system on AOD issues.
- A thorough examination of the Medi-Cal system must be undertaken in relation to impacts on the AOD system and services.
- Understanding and planning for the uninsured population will be just as important as building capacity to serve additional insured individuals.
- Appropriately preparing and developing the AOD workforce will be a critical step.
- Further developing the data collection and reporting system capacity is an important component for the decision-making process going forward.

Substance-Based Findings

Alcohol

The data clearly indicates that alcohol is the biggest substance problem in the state. The following two tables summarize the overall substance use patterns presented in the preceding chapters. The first table displays the relative prevalence of alcohol and other drug usage among California's overall population 12 years old and older, and the estimated percentage of these people needing but not receiving, treatment. The second table highlights the primary drugs of choice among people entering publicly-funded treatment services.

Drug Use in California 12 years and older based on 2006-07 NSDUH

	12 years and older
Past month alcohol use	49.6%
Past month binge drinking	21.6%
Past month marijuana use	6.6%
Past month other illicit drug use	4.0%
Past year non-medical use of pain relievers	5.4%
% needing but not receiving tx for illicit drugs	2.57% (827,367 Californians)
% needing but not receiving tx for alcohol	7.8 % (2,511,075 Californians)

Top 5 Primary Drugs for 07/08 admissions

Top 5 Primary Drugs at Admission excluding detox – CalOMS 07/08	% of Total	Top 5 Primary Drugs at Admission Detox only – CalOMS 07-08	% of Total
Methamphetamine	34.3%	Heroin	36.3%
Alcohol	19.8%	Alcohol	31.0%
Marijuana/Hashish	18.8%	Methamphetamine	11.7%
Heroin	12.0%	Cocaine/Crack	10.6%
Cocaine/Crack	10.7%	Prescription Drugs	8.5%

Together these tables indicate:

- Alcohol is by far the most prevalently used substance.
- The second highest used substance is marijuana which is used 7 ½ times less than alcohol.
- The number needing but not receiving treatment for alcohol abuse or dependence is over three times more than those needing but not receiving treatment for illicit drug abuse or dependence.

- 80 percent of admissions into the publicly-funded treatment system (excluding detoxification services) were for illicit drugs and 20 percent were for alcohol. This proportion has been relatively stable over the five years of data presented in this report. (This is likely the result of the treatment system's categorical funding structure which requires priority for specific populations. The 50 percent treatment referral rate from the criminal justice system impacts the treatment admissions by primary drug which accounts, at least in part, for the high percentage of illicit primary drug admissions.)

Based on student surveys, the consumption patterns for California's youth are similar. In 2007/08, 41.9 percent of 11th graders reported past 30-day use of alcohol, 29 percent past 30-day binge alcohol use and 26.2 percent past 30-day illegal drug use. Reported lifetime use for 11th graders was 66.4 percent alcohol, and 45.6 percent any illegal drug. Those considered High Risk Users (illicit drug) and Excessive Alcohol Users show progressively higher percentages of use from 7th grade through 11th grade as shown below with over 12 percent more Excessive Alcohol Users than High Risk Users.

California Student Survey - 2007/08

	7th Graders	9th Graders	11th Graders
High Risk Users – Illicit Drugs	3.0%	8.3%	16.8%
Excessive Alcohol Users	5.6%	17.5%	29.2%

The research indicates that stopping or delaying youth from starting AOD use has a strong potential to avoid substance abuse problems before they start. The CalOMS Prevention data below indicates that youth is the major focus of publicly-funded prevention efforts currently.

CalOMS Prevention Services by Age – 2007/08

Age Group	Number of Persons Served	% of Total Served	Rate Served per 1,000 population
0 through 11	69,903	12.3%	10.8
12 through 17	301,320	52.9%	84.6
18 through 25	60,653	10.7%	13.9
26 through 44	81,221	14.3%	8.0
45 through 64	47,051	8.2%	5.1
65 and older	9,092	1.6%	2.2

According to the CalOMS Prevention data, nearly 2/3 of publicly-funded prevention services are targeted to the under-18 year old age groups.

These substance-based findings consistently show that consumption patterns and need for treatment are highest for alcohol. According to the NSDUH survey, 50 percent of 12+ year olds in California are estimated to have drank alcohol, and 22 percent have

reported binge drinking, within the past 30 days. Although alcohol consumption is legal for adults (21 years and older), the widespread use of alcohol is related to substantial negative individual, family and societal consequences. This is especially true for underage drinkers, with 30-day alcohol prevalence rates of 42 percent for 11th graders, and 26 percent reporting binge drinking. Estimates of treatment need are consistently highest for alcohol as well. However, publicly-funded treatment data do not show alcohol as the number one drug of choice among those admitted for treatment services.

Marijuana

Marijuana is consistently reported as the second most commonly used drug after alcohol, and by far the number one illegal drug used. The 2006-07 NSDUH estimate for California is 6.6 percent of all 12+ year olds, but the California Student Survey (CSS) numbers suggest a much higher prevalence (24 percent) among young students.

Prescription drugs and opiates

There has been a growing awareness, and recent documentation of, the emerging problems related to the non-medical use of prescription drugs, primarily opioids such as hydrocodone and oxycodone, and other over the counter drugs. Although there are no direct comparisons to other substances for 30-day use, the California NSDUH estimate for past year non-medical use of prescription drugs is 5.4 percent and the CSS estimate for lifetime usage among 11th grade students is 18 percent. The percentage climbs to 35 percent when over the counter drugs are included. These numbers suggest a rapidly growing problem with potentially severe consequences (e.g., overdose poisoning and deaths).

Based on hospitalization and emergency department trend data, the rates for opiate related hospitalizations and emergency department visits is increasing particularly for opiate poisonings. There is also some indication that the increase in the prescription drug problem (primarily opioids) is leading to higher use of heroin.

Methamphetamine

Even though law enforcement still considers methamphetamine the greatest drug threat in California from a criminal justice perspective, prevalence and consequence data from other perspectives suggest a focus on other substances. There have been substantial decreases in amphetamine related hospitalizations and emergency department visits over the three year trend observed, 42 percent and 40 percent respectively. There has also been a corresponding decrease in CalOMS Treatment admissions for methamphetamine from a high in 2005/06 of 41 percent to just over 34 percent in 2007/08. While still the highest primary drug of abuse for treatment admissions, that trend is showing a decline.

Population-Based Findings

Overall Need

Overall AOD services need has been estimated. Following is a summary of the general findings for the continuum of services need in California.

- Over 3 million youth aged 12 through 20 could benefit from universal prevention strategies.
- Approximately 300,000 youth 16 to 17 years old could benefit from selective prevention strategies.
- Approximately 635,000 to 1.75 million 18 to 25 year olds can benefit from early intervention strategies.
- Overall treatment need in California is estimated to be 3.3 million people.

Age Comparisons

Population*	Age 12+	Ages 12-17	Ages 18-25	Age 26+
% of CA population aged 12 years and older	100%	10.9%	14.3%	74.8%
Prevalence Rates (NSDUH)				
% Past month alcohol use	49.6%	15.5%	58.6%	52.8%
% Past month marijuana use	6.6%	6.8%	17%	4.5%
% Past month illicit drug use excluding marijuana	4%	4.7%	8.4%	3.1%
% Past year non-medical use of pain relievers	5.4%	6.6%	12%	3.9%
% Needing but not receiving tx for alcohol/illicit drugs	10.37%	9.74%	23.87%	7.91%
Services and Needs				
% of 07/08 CalOMS Pv served	100%	60.3%	12.1%	27.5%
% of 07/08 CalOMS Tx admissions excluding detox	100%	13.5%	19.1%	67.4%
% of overall total Treatment Need in CA	100%	10.2%	32.9%	57%

*NSDUH survey data is available only for persons 12 and older. Prevention and Treatment services are available for younger person but are excluded in this chart for comparison purposes.

It is clear strictly from a numbers perspective that the 26 and older age group has the highest number of people who could benefit from substance abuse services because it includes the broadest range of ages (i.e., over 40 years); however, the 18 to 25 year old age cohort has the highest rates of alcohol and illicit drug use, the highest percentage needing but not receiving treatment and the second highest percentage of the treatment need, likely a function of the smaller cohort size compared to the 26 years and older age group.

The 18 to 25 year old age group should be a priority population for prevention, early intervention and treatment activities. However, because the vast majority of youth in this age group start their AOD use in their earlier teen years, focusing prevention efforts on the younger age group is also a method of positively impacting the prevalence rates for the 18 to 25 year old age group.

Race/Ethnicity

A thorough analysis of how race/ethnicity impacts prevalence rates; service need, use and outcomes; and the consequences of AOD use is critical in a state as diverse as California. The analysis can enhance understanding of the needs of the population requiring services, provide a data-informed approach to setting policies that could impact different groups, and focus service strategies on the most effective practices.

Limited race/ethnicity data was provided in this report which only serves to inform the reader on some of the issues specific to certain races/ethnicities (i.e., high rate of Hispanic DUI arrests, high rate of African American narcotics arrests, high rate of white women using alcohol during pregnancy). However, all the data necessary to conduct the analysis described above was not available at the time of this report. Subsequent reports must include this data and analysis for a more complete understanding of the AOD service needs in California.

Specific Subpopulations

Specific subpopulations that were examined are listed by priority below based on total estimated number in need of treatment. Only the subpopulations examined in this report are considered for discussion. It should be noted however, that other public service systems may also provide substance abuse treatment services for their specific population which is not calculated into the estimated need identified below (e.g., Veterans Administration, County Mental Health Departments).

1. Approximately 416,000 veterans in California are in need of treatment services.
2. Approximately 275,000 Californians with a serious mental illness and a concurrent alcohol and/or drug problem are in need of treatment services.
3. Approximately 107,000 pregnant women in California are in need of treatment services.
4. Approximately 102,000 homeless Californians are in need of treatment services.

In addition, there are over one million older adults aged 60 years or older who need some level of AOD service. This estimate is based on AOD misuse rather than abuse or dependence, therefore, treatment is not necessarily indicated. The evidence suggests that the misuse is primarily with alcohol and prescription drugs.

Priority Setting Process

Once county input was received, the priority-setting process commenced with ADP's Executive Team using the following criteria as a guide for decision making. In addition SAMHSA's 8 Strategic Initiatives and highlights from the Office of National Drug Control Policy's (ONDCP) National Drug Control Strategy were used to inform the process.

Priority Setting Criteria

Consistent with ADP vision, mission, and organizational structure:

- Consistent with and will not undermine essential vision/mission
- Fits into (or should be added to) existing organizational structure/activities

Feasibility of implementation and sustainability:

- Existence of infrastructure (e.g., staff and facilities, resources availability) or attainable through redirection of resources
- Funding available and sustainable
- Authority to implement is present or obtainable
- Political and cultural acceptability and support
- Workforce knowledge and skills and/or opportunities for training and technical assistance

Timeliness:

- Length of time to results/outcomes within a 3-year time period

Evaluation of program or policy:

- Ability to evaluate/measure effects

In addition to the priority setting criteria, the Executive Team had other key points that they had to consider in their decision making. Specifically, the state staffing reductions; balancing operational needs versus strategic activities; the impact of realignment on the state's role; and how to achieve real change through measurable outcomes.

The three priorities selected from the needs assessment findings are all system level change efforts geared toward building the capacity to significantly impact the substance abuse problems in California, and prepare for the implementation of health care reform. These were deemed the most critical areas as statewide priorities and also serve to support effective AOD services to all special or target populations. In conjunction with these priorities, ADP will continue all operational activities that include work with constituent committees focusing on minority populations, pregnant and parenting women, individuals with co-occurring disorders, veterans, etc.

The three priorities selected are:

1. Increase Health Care Reform(HCR) Readiness
2. Build Capacity for Early Intervention Strategies
3. Employ More Science-Based Prevention Strategies

DISCUSSION OF SPECIAL POPULATIONS

In the prior section, the SNAP process resulted in three priorities, which largely focus on system improvement. The three priorities were developed prior to the release of the new application. To address the requirements set forth in the new application, the following discussion section will detail some of ADP's expansive experiences and findings in working on the issues impacting California's special populations, as well as collaborative partnerships formed across systems. The following discussion section informs the development of three additional "proposed" priorities, which can be found in Planning Steps 3 and 4.

California's Diversity in Unmet Need: A Description of Underserved Populations

California's geographic, racial, and socio-economic diversity creates significant challenges and barriers in special populations accessing substance use disorder (SUD) prevention, treatment, and recovery support services. While ADP has kept special populations' health disparities at the forefront of its program and policy work, persistent barriers remain. Although, ADP's work with special populations spans over a decade, data from ADP's Statewide Needs Assessment and Planning (SNAP) process indicates unmet needs for SUD services across various subgroups. In this time, a variety of behavioral, cultural and systemic issues are emerging that represent some of the key factors underlying ongoing health disparities. The salient issues among high-risk populations such as pregnant women, children and adolescents of substance users, underserved racial and ethnic minorities, the chronically homeless, active military personnel and veterans, individuals with co-occurring disorders (COD), intravenous drug users (IDUs) and persons at risk for or living with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), as well as the criminal justice population are as broad and distinct as the populations in which they exist. The consequences and impacts of unmet treatment need, as well as programmatic and policy improvements required for client access and engagement, are as real as the individuals they impact.

Pregnant Women with an SUD

Data from SNAP provides estimates of California women who drink while pregnant. The most consequential impact of prenatal exposure to alcohol and other drugs is the onset of fetal alcohol spectrum disorder (FASD). FASD can include physical abnormalities, mental retardation and health problems. Long-term effects of prenatal alcohol or

substance exposure may include: long-term cognitive deficits, learning disabilities and poor social adjustment in older children. Older children prenatally exposed to stimulants and other substances may experience limited expressive language and deficits in their language ability. Over-stimulation and self-regulation difficulties are observed with cocaine-exposed children and these are sometimes found in children exposed to other stimulants.

ADP has actively raised awareness of FASD through its participation in the State Interagency Team (SIT) for Children, Youth and Families. As will be demonstrated throughout this Discussion section of Step 2, the SIT is a system-wide collaborative effort that addresses the cross-cutting issues impacting California's most vulnerable populations. SIT was established in 2003 to lead, guide and facilitate local implementation of improved systems that benefit communities and promote the welfare of the common population of vulnerable children, youth and families. SIT targets its efforts where there is a nexus between substance use and child safety, education, workforce readiness and success, maternal/child health, and mental health. Comprised of deputy directors from 10 state agencies, SIT representation includes the Departments of Social Services (CDSS), Education (CDE), Health Care Services (DHCS), Mental Health (DMH), ADP, Developmental Services (DDS) and Employment Development (EDD), as well as the Attorney General's Office, the California Children and Families Commission, and the Workforce Investment Board. SIT promotes shared responsibility and accountability by ensuring that planning, funding and policy are aligned across State departments to accomplish the following goals:

- Build community capacity to promote positive outcomes;
- Maximize funds for programs and services;
- Remove systemic and regulatory barriers;
- Ensure policies, accountability systems and planning are outcome based;
- Promote strengths based practice;
- Share information and data;
- Policy and Programmatic Alignment; and
- Increased Service Access, Utilization and Efficacy

SIT's FASD Work Group (FASDWG)

In April 2009, the SIT FASDWG was established and comprises State representatives from CDSS, DDS, CDE, DMH, DPH, and California Department of Corrections and Rehabilitation (CDCR), as well as a FASD subject matter consultant. The FASDWG subject experts/partners include the Children and Family Futures (CFF) and the Arc. CFF is an advocacy group staffed by experts with specialized knowledge on improving collaborative practice and policy among the SUD, child welfare, Tribal child welfare and family judicial systems. The Arc is a community-based organization (CBO) advocating for and serving people with intellectual and developmental disabilities and their families. Under the direction of the SIT, the FASDWG was tasked with looking at how State departments could positively affect the issue of FASD prevention without any additional State resources. The FASDWG had two broad deliverables:

- Compile a funding matrix across all applicable SIT departments that maps existing resources for pregnant women and families impacted by FASD; and

- Develop a statewide messaging plan that supports local prevention campaigns to address substance use during pregnancy and is aligned with the five points of intervention: pre-pregnancy, prenatal, birth, infant, and school age.

In an effort to break down silos, the funding matrix serves a critical need to further understanding of different State programs and varied funding across departments. The FASDWG realized there could be critical linkages across departments to coordinate scarce resources. Each member completed a matrix specific to their department, which was then combined into a single document to summarize the current available resources for pregnant women and families who could be impacted by FASD, including sexually active women. The matrix also includes programs that do not directly serve clients identified as substance users or experiencing FASD, but could include those populations. The matrix captures information which will improve collaboration at the State level, avoid duplicative efforts, assist the SIT in the assessment of gaps in services, and identify necessary policy changes that impact FASD. The development of the matrix is only a start. In the near future, an analysis will be completed to better inform subsequent policy recommendations.

To streamline public education efforts, the FASDWG decided that department fact sheets on FASD were a critical piece of information dissemination strategy. A FASD Fact Sheet template was designed with consistent and overarching statistics and messages. Each FASDWG member completed the FASD Fact Sheet template and customized it for their specific audience. The FASD Fact Sheets will be used on departments' web sites, conferences, seminars, webinars, etc. to educate any applicable population on FASD. The FASDWG agreed that data from the Department of Public Health (DPH) would be the only data used so all facts are standardized and verified. Each department will update their fact sheet annually and/or when new information becomes available based on the newest data supplied by DPH.

Moving forward, the FASDWG identified several areas where a concerted effort around FASD might be the most effective:

- Educate the court system about FASD because many people with FASD enter the justice system (e.g., criminal, family, juvenile) at some point in their lives;

- Educate women receiving Medi-Cal (Medicaid) services about the impact of alcohol use during pregnancy, and ask the important questions about drinking while pregnant. Approximately 41 percent of births in California are to women who are Medi-Cal recipients;

- Address FASD in currently funded prenatal screening efforts in California counties using a combination of state, federal, and county Proposition 10 funding currently available to the counties;

- Continue to build on the models available for county-level assessments of current levels of prenatal exposure. These models are cited as a national model of a comprehensive survey that establishes clear prevalence data.[19][20]

- Target programs in child welfare and the foster care system. Research indicates there are many children in the child welfare system that are prenatally exposed to alcohol;

- Pursue inclusion of questions about substance use during pregnancy in home visitation programs, specifically the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting program; and

- Any program that conducts home visits should include questions about perinatal substance use.

The FASDWG will continue its collaborative effort with a public health focus. Based on the grim fiscal reality in California, and in particular the staffing shortages experienced by most departments, the FASDWG is exploring options for seeking funding from the health insurance industry and their foundations to pursue some of its work. Certainly, there are industry cost savings that would be gained.

Children of Substance Users

Data from the SNAP process provides treatment admissions data for parents with dependent children. However, data on children of substance users is limited so ADP commissioned the CFF to investigate issues pertaining to this high-risk population. In August 2006, CFF issued its report, "Data on California's Women and Families with Substance Use Disorders." This report provides an aerial view of the intertwined and symbiotic relationship between substance using parents and the effects of substance use upon their children. The findings clearly point to the propensity of SUDs within a family to result in intergenerational long-term negative effects on the children. Included in this section is a synopsis of some of the most salient findings of the report.[21] Children of substance users are often predisposed to wide variety of problems and potential risk factors.[22,23,24] These factors include:

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[19] 2008 report issued by DPH, Perinatal Substance Use Screening in California. 2007 Orange County Health Care Administration Report: Prenatal Exposure in Orange County.

[20] Orange County Health Care Administration Report: Prenatal Exposure in Orange County.

Sharon Boles, Ph.D., Deborah Werner, M.A., Nancy Young, Ph.D., Sid Gardner, M.P.A, et al. California Women, Children & Families Technical Assistance Project (CalWCF): Data on California's Women and Families with Substance Use Disorders, August 200

[22]. Conners, N.A., Bradley, R.H., Mansell, L.W., Liu, J.Y., Roberts, T.J., & Burgdorf, K. (2004). Children of mothers with serious substance abuse problems: An accumulation of risks. *American Journal of Drug and Alcohol Abuse, 30*(1):85–100.

[23]. Price, A., & Simmel, C. (2002). Partners' influence on women's addiction and recovery: The connection between substance abuse, trauma and intimate relationships. Berkeley, CA: National Abandoned Infants Assistance Resource Center, University of California at Berkeley.

[24]. Young, N., Gardner, S., & Dennis, K. (1998). Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy. Washington, DC: Child Welfare League of America.

- effects of prenatal exposure;
- unstable and unsafe family environments;
- greater likelihood of experiencing childhood trauma, violence, abuse or neglect;
- developmental and cognitive delays and deficits;
- proximity to and accessibility of alcohol and other drugs;
- family norms and values which encourage alcohol and drug usage; and
- living part of their lives in out-of- home care and removed from their birth parents.

Prenatal exposure to alcohol or other drugs is only one factor of a myriad of other factors which place these children at risk. Children of parents who use substances may experience sub-optimal home environments (e.g., lack of appropriate and consistent boundaries, family instability). Chaotic home environments and parenting may contribute to developmental, behavioral, health and mental health problems and subsequent delinquency or alcohol/drug usage. Children who are exposed to the production, manufacturing and sales of illicit drugs pose additional health and safety risks. All of these associated environmental factors combined with biological factors, place children of substance users at increased risk for early onset an SUD, as well as predisposes them to a significant number of developmental risks.
Unfortunately, there is little data available regarding the prevalence or needs of these children. Indisputably, however, prenatal and post-natal exposure to alcohol and drugs in a family, and the lifestyle effects of those drugs, negatively impacts children's development.[25] Compared to children of parents who do not use alcohol or drugs, children of parents who do, and who also are in the child welfare system, are more likely to experience physical, intellectual, social, and emotional problems. Among the difficulties in providing services to these children is that problems affected or compounded by their parents' SUDs might not emerge until later in their lives.[26] Children who experience either prenatal or postnatal drug exposure are at risk for a range of emotional, academic, and developmental problems. For example, they are more likely to:

- Experience symptoms of depression and anxiety;
- Suffer from psychiatric disorders;
- Exhibit behavior problems;
- Score lower on school achievement tests; and
- Demonstrate other difficulties in school.

Positive social and emotional child development generally is linked to nurturing family settings in which caregivers are predictable, daily routines are respected, and everyone

[25] Ibid at 4.
[26] Goldman, J., & Salus, M. K. (2003). *A coordinated response to child abuse and neglect: The foundation for practice* [On-line]. Available: http://www.childwelfare.gov/pubs/usermanuals/foundation/index.cfm; Sullivan, S. (2000). *Child neglect: Current definitions and models—A review of child neglect research, 1993– 1998*. Ottawa, Canada: National Clearinghouse on Family Violence; Perry, B. D. (1997). *Incubated in terror: Neurodevelopmental factors in the 'cycle of violence'* [On-line]. Available: http://www.childtrauma.org/CTAMATERIALS/incubated.asp; Kraemer, G. W. (1992). A psychobiological theory of attachment. *Behavioral and Brain Sciences, 15*(3), 493–511.

recognizes clear boundaries for acceptable behaviors.[27] Such circumstances often are missing in the homes of parents with SUDs.

The CFF report found that 67 percent of the mothers that entered treatment with their children had sole custody. These children displayed a number of risks associated with poor physical, academic or socio-emotional outcomes. Some risk factors include homelessness, placement in an intensive care unit at birth, family low-income status, not living in a two-parent home. Out of eleven risk factors, these children exhibited an average of six. Children from the treatment centers were twice as likely to suffer with asthma; three times as likely hearing impaired; and seven times more likely visually impaired than the national averages. Seventeen percent of the children's mothers reported that their child received special instruction (e.g., special education) and 24 percent reported being contacted by the school regarding a behavior problem.[28]

Studies among adolescents with substance using parents indicate that these children are more likely to develop SUDs themselves. Some adolescents mimic behaviors they see in their families, including ineffective coping behaviors such as using drugs and alcohol. Many of these children also witness or are victims of violence. It is hypothesized that substance use is a coping mechanism for such traumatic events.[29] Moreover, adolescents who use substances are more likely to perform poorly in academics and be involved in criminal activities. The longer children are exposed to parental SUD, the more serious the negative consequences may be for their overall development and well-being. Moreover, these children's unstable family life puts them at risk for foster care placement, and as stated earlier, they may be predisposed to becoming substance users themselves.

SIT's Involvement with Adolescent Children in the Foster Care System

The SIT recognizes the unmet needs of adolescents in the foster care system and strives to better coordinate programs and services. Specifically, the SIT targets its efforts towards foster youth involved in the juvenile justice system. It does so, by developing linkages to community-based services, including mental health and SUD services. SIT is actively working to support the following:

- Successful transitions to adulthood for foster youth exiting the juvenile justice system
    - Conduct a preliminary analysis of the potential to share data to identify foster youth involved with the CDCR Division of Juvenile Justice (CDCR/DJJ) and coordinate resources across systems; and
    - Identify partner agencies' common goals for foster youth and resources for "dual status" youth; and

[27] Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press; Kagan, J. (1999). The role of parents in children's psychological development. *Pediatrics, 104*(1), 164–167.
[28] Ibid. at 4.
[29] Kilpatrick, D., Acierno, R., Saunders, B., Resnick, H., & Best, C. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology, 68*(1), 19–30.

- Prioritize CDCR/DJJ foster youth case planning to support increased access and entry into eligible programs and services.

In 2010, SIT accomplished the following on this issue:

- CDCR/DJJ and CDSS drafted a memorandum of understanding (MOU) to share data to identify foster youth in DJJ;
- The California Administrative Office of the Courts (AOC) has agreed to modify the Court's JV-732 "Commitment to DJJ" form to include the identification of foster youth; and
- CDCR/DJJ will use the CDSS Foster Youth Resource Toolkit to inform foster youth in CDCR/DJJ of the availability of programs and services and SIT members provided updated information to CDSS on services administered by their departments.

The following were identified as 2011 deliverables:

- Finalize data sharing MOU between CDSS and DJJ; and
- Conduct a resource information sharing session for self-identified foster youth to link them with services in the community for which they are eligible.

Strengthening ways to link youth exiting DJJ is especially timely and important with the enactment of California Assembly Bill (AB) 1628, which transferred responsibility for supervision of these youth from CDCR/DJJ to the counties effective January 2011.

In addition to the specific subset of foster care youth involved with the juvenile justice system, the SIT is broadly working to aggregate data sharing for accountability for all youth in the foster care system. This includes an analysis of the potential for using outcomes data from systems other than child welfare services (e.g. health, education, SUD treatment, etc.). Outcomes data from these other systems must focus on indicators of child and family well-being and satisfy accountability reporting as required by California Child Welfare Outcomes and Accountability System (AB 636). This effort could result in multiple State departments sharing data and identifying common clients. Progress to date on this issue includes:

- The AOC has completed and published four policy briefings in the new series "Sharing Information about Children in Foster Care." These briefings cover health, education, mental health and SUD treatment. The also further the recommendations of the California Blue Ribbon Commission and the California Child Welfare Council (CWC) on overcoming barriers to information sharing; and

- The CWC issued a statement urging collaborative efforts by federal and State government, local public and private child serving agencies, the courts, tribes and tribal organizations. The CWC recommended implementing information sharing initiatives and transforming the way information is shared with each other.

The SIT has continued to emphasize the importance of removing barriers to data sharing to improve services and outcomes accountability, as well as designing the technology that would facilitate data sharing. The SIT acknowledges several efforts are underway related to data sharing and it is important to know what these are to identify ways to leverage their experience, learning and resources. For 2011, the SIT will focus on the following deliverable:

- Establish data sharing MOUs between CDSS and ADP, CDE and CDCR/DJJ.

Underserved Racial and Ethnic Minorities & LGBTQ

As previously indicated, data from ADP's SNAP process shows a significant need for SUD services among racial and ethnic minorities. To prepare the SUD field in serving diverse clients, over the years ADP has provided the necessary technical assistance to counties and providers on the unique needs of underserved racial and ethnic minorities. ADP's new multi-year Community Alliance for Culturally and Linguistically Appropriate Services (CLAS) initiative builds on this prior commitment. Notably, CLAS, along with ADP's participation in SAMHSA's "Behavioral Health Policy Summit to Address Disparities in Health Care Reform," will help ensure California's SUD system is culturally competent in the post-ACA health care environment.

Similarly, ADP's Program Services Division, Prevention Services Branch, is strategizing efforts on targeting specific racial/ethnic minorities and populations (for example, Asian American, Vietnamese, Korean, Japanese, Russian, LGBTQ, gang members, criminal and juvenile justice populations, homeless, foster youth, and children of substance using adults). An example of one effort is Marin County Next Generation Scholars' Marin Youth Pride, which is comprised of youth from all of Marin County's high schools of all sexual orientations to work on an annual float. The float will inspire those who are still in the 'closet' to come out as well as educate the community about how homophobia can create an environment causing LGBT youth to have less accepting environment to grow up in. ADP's Resource Center will also continue to provide resources in languages other than English, and ADP will provide training and materials in Spanish when requested.

SIT's Work Group to Eliminate Disparities (WGED)

In addition, ADP is an active participant of SIT's Work Group to Eliminate Disparities (WGED), which focuses on reducing racial disproportionality and disparities in outcomes across systems. The end goal of the WGED is to progress toward fairness, equity, and quality of services for California's diverse racial, ethnic and cultural children, youth and families. Reducing racial disproportionality and disparities in services and outcomes is an ongoing and long-term effort requiring leadership, education and training, data collection at relevant points in the decision-making process, data analysis, information sharing, and collaboration across State departments and service systems. ADP assists in this effort by making recommendations to the SIT regarding deliverables and activities pertaining to SUD services. Broadly, the WGED focuses on:

- Supporting and leveraging common efforts and goals of State departments to address disproportionality and disparities;

- Participating as the State-level team on the California Disproportionality Project (CDP);

- Forming recommendations for State policy, regulatory, and practice changes needed to address disproportionality and disparities; and

- Enhancing departmental efforts through disproportionality and disparities "Courageous Conversations," a strategy for raising institutional racism as a topic of discussion that allows those who possess knowledge on particular topics to share it, and those that lack knowledge to learn and grow from the experience.

In 2008, the CDP was created to conduct research, develop recommendations, and garner public support for reducing racial disproportionality and disparities for African-American and American Indian families and children in child welfare. Fifteen teams, representing 12 California counties and a State-level team, included parents, youth, community partners, tribal partners, child welfare agency workers, supervisors, managers, and leaders, as they worked collaboratively for 22 months to address disproportionality and disparities for African-American and American Indian families and children. These teams focused intensively on raising awareness, developing and delivering training, engaging partners, and testing changes in practice. They were supported by expert faculty members as they used aspects of three key methodologies to guide their work: the Breakthrough Series Collaborative, the Family to Family Initiative, and an American Indian Enhancement Team.

The SIT WGED participated in the full CDP as the State-level team, which enabled them to better understand the issues surrounding the work first-hand as they listened to counties. They were also able to recommit to this work on a statewide level. The individual SIT team members planned to infuse their respective agencies with the learnings from the CDP. Addressing disproportionality and disparities is becoming part of the normal training expectations across the State. The State-level team together with the county teams helped inform the State on the direct work undertaken by counties.

This project identified four key system-level elements that are required to support agency-wide changes: 1) ongoing and continuous training and awareness; 2) committed and engaged leadership; 3) dedicated and supported workgroups; and 4) an intentional focus on sustainability. Additionally, participating teams developed and/or tested promising practices to help address the issues of disproportionality and disparities. These practices included race/culture-specific practices and general child welfare practices. The WGED presented a final report on participation in CDP with recommendations for SIT action items.

During 2010, the WGED focused on raising awareness of factors contributing to racial disproportionality and disparities though "Courageous Conversation" events, strengthening local and State partnerships through collaborative projects, training and

education, and establishing a work group structure. The WGED completed a resource guide for distribution that highlights education and training opportunities within each member department on reducing disproportionality and disparities.

For 2011, the WGED's proposed work plan includes concentrated efforts for enhancing outreach and policy change through leadership, communication, education, and future collaboration. The WGED proposes to complete the following major deliverables this year:

- Develop and disseminate a quarterly WGED Newsletter to educate participating departments about the work of the WGED and its member agencies and highlight leadership commitment to address disproportionality and disparities;

- Research the viability of a SIT/WGED Website; and

- Launch the Interagency Collaboration Project in which the WGED member agencies will report to the work group regarding activities at their departments to reduce disproportionality and disparities. The aim is to identify common issues and opportunities to collaborate and leverage resources.

The Chronically Homeless

Efforts to reduce homelessness through substance use intervention and prevention acknowledge that the most effective strategy is "housing first." ADP's funding is generally unavailable for housing services for substance users. The exception is the California Access to Recovery (CARE), which authorizes increased opportunities for treatment and recovery support services for those aged 12-20. Until recently, the voter approved voter-approved Substance Abuse Crime Prevention Act (SACPA) also allowed for the provision of ancillary support services. Due to California's ongoing budgetary issues, however, this program funding was eliminated.

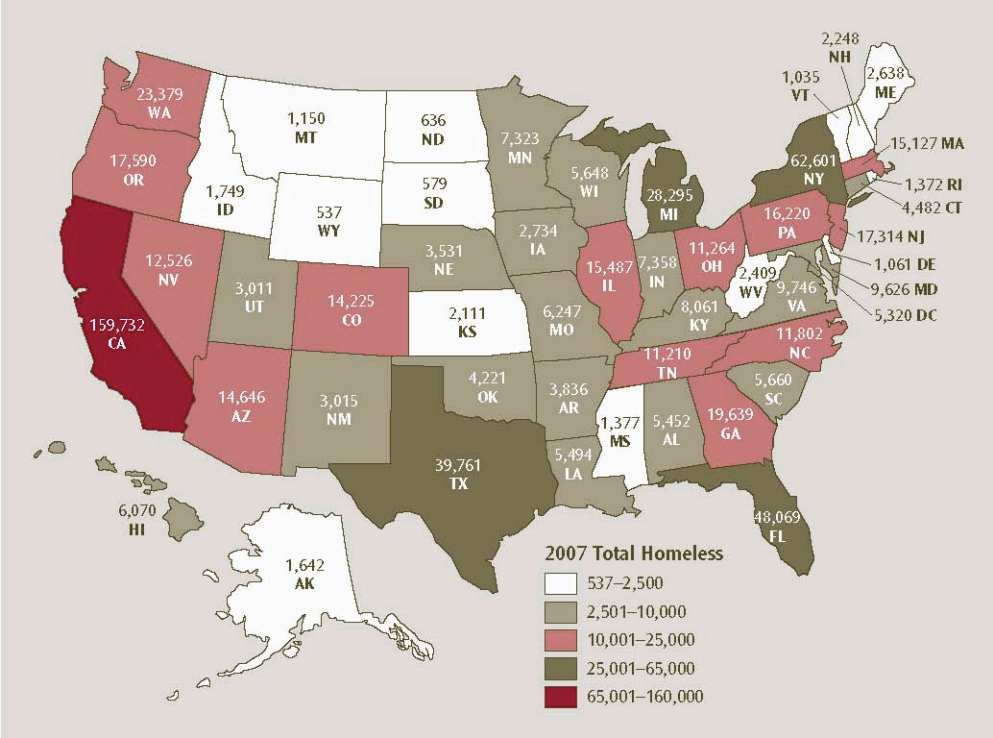
Part of ADP's COSSR effort is to re-engineer California's continuum of services (COS) for SUDs. This includes individuals who are chronically homeless or at risk of becoming homeless and who require a comprehensive and integrated system of support services to achieve ongoing stability. Ensuring that services are in place to meet the needs of this population requires expanding community-based service capacity in particular for health, mental health, and addiction services. While there certainly are a significant number of homeless persons dealing with substance use or dependency, COSSR did not spotlight specific populations. Rather it addresses improving and coordinating the overall delivery of services system wide, not by categories by which individuals may be identified. For individuals with SUD problems, particularly the homeless population, integrated services are essential.

Homelessness in California

California accounts for the largest percentage, 24 percent, of the nation's estimated homeless persons. In 2007 California had one of the highest rates of chronic

homelessness in the nation with 27 percent chronically homeless.[30] The National Coalition for the Homeless estimated in 2006 that of California's homeless population approximately 24,000 were veterans and more than 17,700 were children.[31] However, these estimates are based on data collected prior to the economic crisis and these numbers most likely increased significantly due to the recession. The following map from the National Alliance to End Homelessness shows California Homeless estimates in comparison to the rest of the nation.[32]

Homeless Estimates by State, 2007



Source: National Alliance to End Homelessness, 2009

Chronically homeless individuals experience high rates of serious mental illness and SUDs, as well as other chronic health issues that precipitate frequent use of high cost emergency care and lengthy inpatient visits (Caton et al., 2007). National studies on the characteristics of homeless persons indicate that people of color disproportionately represent the homeless. Studies also found an average of 16 percent of the single adult homeless population suffers from some form of severe and persistent mental illness.[33]

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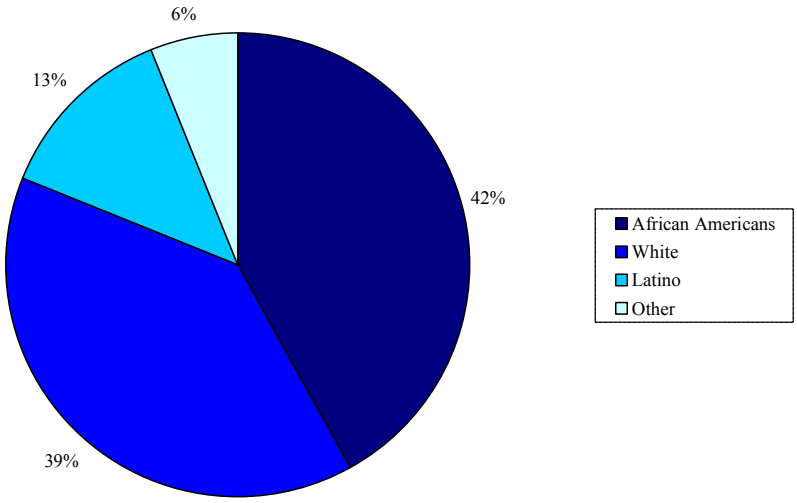
[30] "Homelessness Counts: Changes in Homelessness from 2005 to 2007," National Alliance to End Homelessness (NAEH). Pub 2009. Downloaded 08/23/11, http://www.endhomelessness.org/content/general/detail/2158

[31] More than 292,624 California children experience homelessness each year according to the data collected by the McKinney-Vento Educational Programs.11 Education for Homeless Children and Youth Program, Title VII-B of the McKinney-Vento Homeless Assistance Act as Amended by the No Child Left Behind Act of 2001,*Analysis of 2005–2006 Federal Data Collection and Three-Year Comparison*, National Center for Homeless Education, June 2007. Number of children includes the estimated number of children ages 0–5 who are not yet enrolled in school.

[32] Ibid at 10.

[33] Folsom, D.P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S., Garcia, P., Unützer, J., Hough, R., and Jeste, D.V. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients With Serious Mental Illness in a Large Public Mental Health System." *American Journal of Psychiatry*, 162:370-376. Feb. 2005.

National Estimated Homeless Population by Race



Despite the limited funding streams available to combat homelessness, ADP has worked closely with the Co-Occurring Joint Action Council (COJAC) for several years. COJAC's work involves the development of a Co-occurring Disorders (COD) State Action Plan, which directly addresses the issue of homelessness as it relates to the COD population. The COD Unit at ADP received California Mental Health Services Act (MHSA) funding from DMH to provide staff support to the Housing and the Funding Subcommittees of COJAC. The COJAC Housing Subcommittee has developed the Housing Compendium, which provides a list of potential housing opportunities for COD clients, many of whom are homeless. This document is available on the Web at: http://www.adp.ca.gov/cod/housing.shtml.

Additionally, the COJAC Housing Subcommittee provided to ADP and DMH recommendations on the proposed State Homeless Plan. Their recommendations focused on possible changes to the plan that could better serve COD clients. The Housing Subcommittee's recommendations specifically addressed the availability, accessibility and integration of support services needed by families who are homeless or at-risk of homelessness.

In 2007, the California Research Bureau (CRB) released a report about the status of education and homeless youth in California, called The Educational Success of Homeless Youth in California." The report found that in 2005-2006, there were 196,722 homeless children and youth enrolled in school in California, though they noted that this number is likely low. The CRB identified the following barriers to successful education of homeless youth:

- It is difficult or impossible for youth to both attend school and provide their own food, shelter, clothing, and healthcare, particularly since homeless youth are at

increased risk of physical illness and mental health problems. Many traditional homeless services programs will not or cannot serve youth;

- Youth who are not comfortable in a school setting are unlikely to attend; therefore, the report emphasized the importance of programs and support groups designed for youth who differ from their peers, particularly because non-conforming youth (LGBTQ and parenting youth, in particular) tend to be over-represented among the homeless youth population;

- Youth are unlikely to initiate contact with service providers; therefore, dropout recovery programs must include hands-on outreach by staff trained in youth services; and

- Gaps in child welfare services are a primary cause of youth homelessness; many homeless youth experience abuse and neglect both at home and in foster care.

CRB also states that forums used to solicit feedback from homeless youth, found that the services considered most important among homeless youth included (in no particular order): mental health treatment, substance use treatment, life skills training wraparound services, food programs, case management, job-skill development, family mediation, affordable housing, non-judgmental service providers, and consistent rules and structure.

Transitional Housing

Obviously, transitional housing is a critical link to bridging the gap between homelessness, ongoing sobriety and permanent housing. Unfortunately, there are currently no funding sources within California's SUD service system that will provide a reimbursement mechanism to broaden this link. As a result, ADP is working with its stakeholders, including the County Alcohol and Drug Program Administrators of California, to examine developing regulatory language surrounding the formal integration of transitional housing into its continuum of SUD services. ADP is also pursuing the use of SAPT Block Grant as a funding source and awaits further guidance from the federal government on the parameters surrounding transitional housing reimbursement. California has identified a variety of special populations as being the most vulnerable to chronic homelessness. As previously discussed, existing data supports the high need among veterans, individuals with COD and at-risk youth.

ADP has worked at the State level with other agencies to create opportunities for prevention, intervention, and treatment services in shelter programs and outreach to this population. These efforts include working with housing agencies regarding the provision of sober and transitional living. ADP also disseminates and provides links to resources on its website regarding best or evidence-based practices for delivering SUD services to individuals who are homeless or at-risk of homelessness to our service providers.

Active Military Personnel and Veterans

Issues surrounding the availability of treatment services to address specific veteran conditions are becoming critical due to limited capacity, funding, and treatment facilities located far from veterans homes. Additionally many service members who need help are not seeking it because of the stigma associated with mental health and SUD treatment. Unfortunately, alcohol dependence may be on the rise for our future veterans. A study in the American Journal of Preventive Medicine reported of the active-duty military surveyed, 43.2 percent reported binge-drinking at least once the previous month. The average binge-drinking episodes in a year were 29.7. Military personnel under 26 accounted for nearly two-thirds of all the episodes. These rates are similar to those found in studies on college students and may reflect a correlation related to age rather than directly related to military personnel.[34] If there is an age correlation, corresponding rates for binge-drinking should be found in veterans under the age of 26.

The State of California had the largest population of veterans at 2,569,340 according to the 2000 Census. In October of 2008, the Department of Veterans Affairs reported that California had the highest number of women veterans in the nation at 166,984. The ongoing deployment of Californians to the conflicts in Afghanistan (Operation Enduring Freedom - OEF) and Iraq (Operation Iraqi Freedom – OIF) will increase California's veteran population. California has deployed 148,028 troops; 22,305 troops from California were on deployment as of February 29, 2008.[35]

Studies on veterans with co-occurring substance use disorders and post-traumatic stress disorder (PTSD) show the onset of alcohol and substance use is often associated with the symptoms of PTSD. Increases in PTSD symptoms are frequently paralleled with an increase in substance use.[36] There is an unprecedented wave of new veterans with traumatic brain injury (TBI) and PTSD. Over 1.7 million service members are deployed in the wars in Iraq and Afghanistan, many of them with multiple tours of duty. The conditions in these wars are a recipe for PTSD, with repeated deployments and 24/7 full exposure to extreme combat trauma. Approximately one-third of those returning from combat will develop PTSD, COD or other mental health issues.[37]

One preliminary study of Department of Defense prevalence surveys shows that "this generation of veterans is more likely to experience trauma. As veterans complete repeated tours, they are exposed to more trauma and experience a greater prevalence of mental health issues (40 percent) and of those upwards of 60 percent also experience

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[34] Neale, Todd. (2009, February 16). *Binge Drinking Remain Prevalent in the U.S. Military*. Retrieved from http://www.medpagetoday.com/

[35] Department of Defense. U.S. Troops Deployed: Operation Enduring Freedom, Operation Iraqi Freedom, Primarily Iraq and Afghanistan. Retrieved from http://majorityleader.house.gov/docUploads/DeployedJan312007.pdf

[36] JD Bremner, SM Southwick, A Darnell and DS Charney**.** (1996). *Chronic PTSD in Vietnam combat veterans: course of illness and substance abuse*. Retrieved from http://ajp.psychiatryonline.org/cgi/content/abstract/153/3/369

[37] Department of Alcohol and Drug Programs. (2009). *Veterans and Suicide*. Retrieved May 2009 from http://www.adp.ca.gov/veteran/suicide.shtml

a SUD."[38] Studies to date suggest that 10-18 percent of combat troops serving in Operation Enduring Freedom/Operation Iraqi Freedom may develop PTSD following deployment, and the prevalence does not diminish over time. Consistent with a wealth of prior research, there is a robust association between the cumulative burdens of combat and operational stressors and probable PTSD.[39]

The Veteran Affairs Initiative

In an effort to address the SUD treatment needs of California's veterans, in 2008, ADP launched the Veteran and Service Members Awareness Initiative (VAI). Through the VAI, ADP initiated collaboration with the California Department of Veteran Affairs (CDVA). This collaboration resulted in the development of a "Commitment Plan" between ADP and the CDVA, which involves the following key components:

1. Increase public awareness about the need to provide services to veterans and their families. Support a coordinated approach lead by ADP's mission to meet veterans' and service member's issues.
    - Coordinate SUD treatment services at the county and community levels, through ADP's Webpage and publications devoted veterans and their families on relevant issues to this special population. Enhance outreach and communications through peer-to-peer counseling and client-informed services and in the areas of employment, housing/homelessness and mental health care.
    - Increase the SUD treatment field's awareness on the Veterans Administration (VA) services. Disseminate information through counties and providers on VA benefits and services.

2. Develop a collaborative network on the continuum of SUD services available through the military service and local military service organizations.
    - Build administrative and direct service capabilities by collaborating with SUD county administrators, associations, subject matter experts, SAMHSA, DMH and CDVA to identify immediate and long-term training needs.
    - Develop a training plan and delivering specialize training on veteran issues including COD, PTSD, trauma and women veterans issues.
    - Conduct outreach at deployment stations to provide information on SUD services to the military and their families.
    - Research and identify potential funding sources for SUD treatment services for veterans, including federal and private funding sources.

[38] Danforth, K.I. (2007). *Change in mindset brings veterans care into a new era*. Northeast Addiction Technology Transfer Center. 6(1), 11.

[39] National Center for Post Traumatic Stress Disorder. (2009) *PTSD in Service Members and New Veterans of the Iraq and Afghanistan Wars: A Bibliography and Critique*. v20(1).Retrieved from http://www.mentalhealth.va.gov/ptsd/files/pdf/V20N1.pdf

Criminal Justice Population

According to the most recent statistics from CDCR, more than 120,000 adults were on parole in California as of December 2010. The overwhelming majority of parolees are male (90 percent), and while some may qualify for Medi-Cal under current rules, some studies suggest that the majority of parolees are uninsured (Mallik-Kane and Vischer, 2008; Alameda Health Task Force, 2009). Despite being relatively young (the average age of California parolees is 37), the health care needs of the reentry population are substantial, particularly for mental health care and SUD services. Nearly two-thirds of California inmates report drug abuse or dependence problems and more than half have reported a recent mental health problem. The re-entry population also has a high prevalence of infectious diseases, including HIV (one percent), tuberculosis (13 percent), and hepatitis B and C (13 percent), as well as high rates of common chronic conditions such as hypertension (18 percent) and asthma (14 percent) (Davis et al., 2009).
A considerable amount of national research over the past decade has shown that incarcerated women, compared to their male counterparts, more often report extensive emotional, physical, and sexually abuse.[40] These experiences often lead these women to become chronic substance users and more prone to developing co-occurring mental and physical health problems. In fact, one study explored exposure to trauma, mental health functioning, and treatment-program needs of women in jails and found high levels of exposure to trauma (98%) – especially interpersonal trauma (90%) – and domestic violence (71%) among incarcerated women, along with high rates of PTSD, substance use problems, and depression.[41]

Extensive national research on female jail and prison populations indicates that there is an overwhelming prevalence of childhood histories of exposure to traumatic events, affecting between 77 percent and 90 percent of incarcerated women.[42] Thirty-six percent of the women also had mental disorders. These research findings indicate that many incarcerated women face incredible barriers in meeting goals of economic and social independence, family reunification, and reduced involvement in criminal activities without adequate attention to addressing the trauma underpinning their PTSD, substance use and mental health problems.

ADP has made significant efforts in improving services for women, including incarcerated women, through its Office of Women's and Perinatal Services (OWPS). OWPS increases communication to the field on best practices and research on women-specific issues and provides training and technical assistance using nationally recognized experts in the field. Dr. Stephanie Covington, who is a renowned subject-

[40] Messina, N., Burdon, W., Hagopian, G., & Pendergast, M. (2006). Predictors of prison therapeutic communities treatment outcomes: A comparison of men and women participants. *American Journal of Drug and Alcohol Abuse*, *31*(1), 7-28.
[41] Green, B., Miranda, J., Daroowalla, A., & Siddique, J. (2005). Trauma, exposure, mental health functioning, and program needs of women in jail. *Crime & Delinquency* *51*(1), 133-151.
[42] Messina, N., & Grella, C. (2006). Childhood trauma and women's health outcomes: A California prison population. *The American Journal of Public Health*, *96*(10), 1842-1848.

matter expert in the field of gender-responsive, trauma-informed services, was a consultant for ADP. Dr. Covington led trainings that were targeted for counselors, clinicians, and program administrators. The trainings offered a comprehensive treatment model that integrated theories of addiction and women's psychological development. It emphasized the key issues of self, relationships, sexuality, spirituality, and the therapeutic techniques for dealing with these issues. Dr. Covington's curriculum is specifically adaptable for use with women in the criminal justice system.

Additionally, APD has brought attention to treatment issues, trends, and practices for women through Substance Abuse Research Consortium (SARC) meetings. SARC meetings offer an opportunity for professionals from a variety of disciplines (academic and agency research, law enforcement, criminal justice, treatment practice, and policy analysis) to exchange information on California substance use trends, promising prevention and treatment strategies, criminal justice/social service partnerships, and other substance abuse-related topics. In 2007, SARC meetings included presentations on trauma-informed approaches for women in treatment for addiction, childhood adverse events and current traumatic distress in the California prison-based population, FASD, and SUD treatment issues among older women. Going forward, ADP will continue its record of ensuring the SUD field provides gender-specific care through the CLAS initiative.

In the past few years, efforts to balance the state budget resulted in elimination of program funding for SUD treatment, including funding for the voter-approved SACPA funds for diversion programs and the Offender Treatment Program. Despite elimination of program funding for these stand-alone programs, the passage of health care reform is incredibly timely. By including SUD treatment as an essential health benefit, the ACA represents an opportunity to serve criminal justice clients in 2014 through Medi-Cal expansion and Exchange coverage. Research findings based on coverage expansions in other states indicate that the newly-eligible Medi-Cal population will likely include a sizeable subset with prior criminal justice involvement and significant unmet medical needs, mental illnesses and SUDs.

The ACA's coverage expansion presents several opportunities as well as challenges in serving this population. Cross-system collaboration will be necessary to meet client needs. This includes: early identification of this population's medical, mental health and SUD treatment needs; connections with appropriate community-based services; coordinated, case management services; and appropriate monitoring and follow-up with criminal justice partners. In 2014, the criminal justice system could become a strategic partner to state Medicaid agencies for enrolling newly-eligible individuals upon release from jail.

ADP has experience in the delivery of early intervention, prevention and treatment strategies to the criminal justice population. Through its participation in the federal Screening, Brief Intervention, Referral and Treatment (SBIRT) grant, California initiated a demonstration project, entitled Los Angeles SBIRT (LASBIRT). The primary purpose of this demonstration project was to test whether a public health intervention that screened short-term detainees (72-96 hours) for tobacco, alcohol, and any psychoactive

substances could reduce recidivism in the Sheriff's and/or LAPD's jail systems and assist offenders to successfully reintegrate into the community. Project participants were screened for substance use risk factors upon their release from custody and referred to treatment if they needed more extensive services.

Although SBIRT is traditionally used in health care settings, California was innovative by SBIRT services with the criminal justice population. LASBIRT project outcomes include:

- reduced criminal behavior and recidivism
- reduced substance use and dependence
- increased employment/school enrollment, mental and physical health stability, housing stability; and
- increased social connectedness.

California's success in implementing SBIRT services in both medical and non-medical settings resulted in ADP including a 2011 SNAP priority for building capacity for early intervention strategies. This priority includes a goal of expanding early intervention services, such as SBIRT, into multiple settings.
As re-entry/parolees are released and enrolled in Medi-Cal or Exchange coverage in 2014, there is an opportunity to build upon California's success with LASBIRT. The criminal justice system, Medi-Cal, the Exchange, and the SUD field can engage in cross-system collaboration. Efforts targeted at identifying individuals needing SUD treatment followed by enrollment in coordinated systems of care that will address unmet physical and behavioral health needs.

Co-Occurring Disorders

The Governor's Budget Act of 1995-96 mandated ADP and DMH actively seek methods to eliminate barriers between the SUD and mental health treatment systems at both the state and local levels on behalf of persons with COD. From that time, ADP and DMH staff partnered with county alcohol and drug program administrators, mental health directors, representatives from non-profit organizations, consumers, and other advocates to form the COJAC to work on integrated strategies to eliminate barriers to the provision of services for persons with COD. In 2004, COJAC released its final report that noted target populations along with strategies. This report can be accessed at: http://www.adp.ca.gov/COD/index.shtml

The Mental Health Services Act (MHSA)

Concurrently, in 2004, California voters passed the MHSA as Proposition 63. Two key tenets of the MHSA are: 1) effective services for people with serious mental illness must include "whatever it takes" for recovery, and 2) those services must be integrated. "Whatever it takes" refers to funding for a wide array of clinical and supportive services beyond mental health care, notably including such things as housing and treatment for COD. Integrated refers to services that are concurrently delivered by a coordination team of caregivers, often sharing single sites. Among the most important services to integrate are mental health and treatment for alcohol and other chemical dependency.

In 2005, the DMH provided MHSA funding to the ADP for the expansion of the COD Unit. The COD Unit is a collaborative effort between the two departments and worked to accomplish the goals of the MHSA. Although, the DMH funding to ADP for the COD Unit recently ended with State Fiscal Year 2010-11, going forward ADP will continue to fund this unit in support of the important work within COJAC.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) was created to provide oversight, accountability and leadership on issues related to the implementation of the MHSA. In 2007, the MHSOAC Report on COD within California delivered the following key findings:

1. Approximately one half of the people experience one of these conditions - a mental illness or a SUD- also have the other condition. The proportion of co-morbidity may be even higher in adolescent populations.
2. Availability of integrated treatment for mental health and substance use problems is currently the exception rather than the rule.
3. Numerous studies demonstrate that integrated care is necessary for successful treatment of COD. Other care models, such as sequential or parallel care, have very limited effectiveness.
4. The Adult System of Care programs in the mental health system appear the only significant publicly-funded programs that offer integrated care in mental health or SUD treatment facilities. Virtually all other programs provide treatment for only mental illness or substance use. Most private insurance coverage and other treatment for mental illness or SUD are similarly separated.
5. Insufficient support for integrated COD programs leads to a paucity of both treatment facilities and properly trained clinicians. Both are essential to provide the full spectrum of necessary care. The lack of such facilities and experts restricts access to service not just for outpatient care, but also for inpatient mental health units with COD capability.
6. Kaiser Permanente's data indicates that the cost of providing the SUD services is more than offset by the savings in physical health care. As a result, they provide unlimited SUD treatment, even when it is neither funded nor mandatory.
7. People with COD are disproportionately represented in the criminal justice system, largely as a consequence of the lack of access to mental health and SUD services.
8. Law enforcement officials and judges frequently find that individuals are incarcerated simply due to the lack of available treatment options for mental health and substance use.
9. People with mental illness in prison do not receive adequate or appropriate care. Prison health officials are not sufficiently trained in offering rehabilitative and recovery-oriented services, which would prepare an individual with mental illness for success after discharge.
10. People with COD have high recidivism rates in the prison system.

11. A pilot program begun in 2000 showed that the recidivism rate can be significantly reduced by offering such care to parolees with severe mental illnesses.[43]

Persons who are Intravenous Drug Users, At Risk for HIV/AIDS, and the Identification and Surveillance of Hepatitis C Virus and Tuberculosis

Prevention, treatment, recovery, and care efforts must strengthen evidence-based, non-judgmental strategies grounded in the principles of harm reduction. These efforts must engage people who use alcohol and other substances to enter substance use treatment. SUD treatment, should be designed to reduce sexual and substance-related risks, expand access to effective addiction treatment, provide high-quality HIV care, and reduce ethnic and racial disparities in SUD services, infection rates, disease, and death. As such, integrating hepatitis C, HIV, and tuberculosis screening in SUD programs and services is an important strategy that addresses the variety of needs among those accessing SUD services.

Intravenous Drug Users

Injection drug use is a major risk factor for HIV, and alcohol and substance use are strongly linked to sexual risk. People who inject drugs account for approximately 30 percent of all people living with AIDS in the United States. African Americans and Latinos face disproportionately high rates of HIV due to injection drug use. Pervasive stigma towards drug use among health care providers results in unequal treatment for people with a history of drug injection, leading to suboptimal care. People living with HIV who inject drugs face high barriers to medical care and antiretroviral treatment. These barriers lead to increased mortality from AIDS-related illnesses and other causes, including liver disease and overdose. During a four-year period, California SUD programs treated 136,493 unique individuals who reported injection use in the last 12 months/past 30 days.

With some notable exceptions, state and local governments are minimally addressing the complex social and medical needs of IDUs that are not in drug treatment programs. Identifying and serving the needs of IDUs outside of the drug treatment system can be improved. Research indicates that fewer than one-half of all injectors report utilizing any SUD treatment services in their lifetimes. Clearly, substance and injection drug use is linked to new HIV and viral hepatitis cases. SUD services should aggressively seek out high-risk, hard-to-reach IDUs and offer them HIV and other communicable disease testing, access to treatment and the support. Remaining in treatment—both for HIV and for SUD is critical in achieving better outcomes.

It is also important to recognize that the social stigma that exists in this country against IDU is institutionalized in ways that affect the health and wellness of IDUs and their communities. This stigma probably deters many people from beginning injection.

[43] Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders, Second Draft, 2007.

However, once a person begins injection, that same stigma can pervade every aspect of an individual's life, determining where and how they live, whether or not they receive health care, whether they are treated well or poorly in many different situations and whether they are free or imprisoned. Incarceration increases risk of disease transmission and overdose, and further jeopardizes IDU health. Homophobia, sexism, racism, ageism, classism, and other oppressions that IDUs face, and sometimes perpetrate, also affect IDU health. Additionally, it is well documented that IDUs of color disproportionately bear the burden of HIV disease. Youth who are IDUs also experience multiple oppressions resulting in health disparities. Understanding the debilitating effects of discrimination must be a priority for research, service design and delivery.

California's providers and CBOs are crucial points of intervention and care. Substance users interact with virtually every social service system in California. Syringe exchange programs are taking the lead to engage and serve current IDUs, however, there remain many untapped opportunities for community-based service programs to help reduce negative health outcomes for drug users, and enhance drug user health and wellness.

Syringe Services Programs

Historically, syringe services programs (SSPs) have not been included as part of a comprehensive network of SUD prevention and treatment services reimbursable by SAPT Block Grant funding. However, the U.S. Surgeon General's recent determination endorsing SSPs has created more opportunities for effective interventions in preventing HIV and other blood-borne pathogens such as hepatitis B (HBV) and hepatitis C (HCV) transmission. ADP is currently awaiting federal guidance that will clarify use of SAPT Block Grant funds for SSPs following the Federal Fiscal Year 2010 SAPT Block Grant award. Once this guidance is issued, ADP will work with its sister agency, the California Department of Public Health, Office of Aids (CDPH-OA), counties and providers, and other relevant stakeholders in developing the appropriate policies and protocols for including SSPs in California's continuum of SUD services.

California has continued its effort to address the needs of IDUs and reduce disease transmissions caused by injection drug use. In 2004, California established the Disease Prevention Demonstration Project (DPDP). The DPDP formed a collaboration between pharmacies and local and state health officials for the purpose of evaluating the long-term desirability of allowing licensed pharmacists to furnish or sell up to ten nonprescription hypodermic needles or syringes in participating cities and counties. Currently, California has two active bills in the Legislature. Senate Bill 41 seeks to allow wider access to new needles and syringes by allowing doctors and pharmacists to sell up to 30 needles and syringes without a prescription. Assembly Bill 604 authorizes DPH to implement SSPs in high-risk areas statewide as part of a comprehensive network of SUD services.

Persons at Risk for HIV/AIDS

As of December 31, 2010, 159,329 AIDS diagnoses and 41,892 HIV infections were reported in California. The epidemic in California is predominantly among men who

engage in sex with men (MSM) and Whites, although the proportion of cases among people of color, women, and heterosexuals continue to increase. African Americans, in particular, are disproportionately impacted by HIV/AIDS. MSM and MSM/IDUs account for 90 percent of reported AIDS cases and 86 percent of HIV cases. Whites account for 54 percent of AIDS cases and 47 percent of HIV cases. MSM exposure accounts for 67 percent of both AIDS cases and HIV cases. Forty-five percent of individuals reported with AIDS are still living.

People of color in California are disproportionately impacted by the HIV/AIDS epidemic, with their rates of infection continually increasing over time. In 1988, for example, people of color made up less than 30 percent of all new AIDS cases reported that year. By 1997, the majority of new annual AIDS cases were occurring among people of color. As of December 31, 2010, African Americans constituted 18 percent of HIV/AIDS cases, while Hispanics increased to 26 percent. Asian/Pacific Islanders constitute 3 percent, while Native Americans and Alaskan Natives constitute 0.4 percent. Women, primarily exposed to HIV through heterosexual contact or IDU, constitute 10 percent of HIV/AIDS cases, and Transgender individuals constitute 0.6 percent.

Barriers that Affect Underserved Populations

As previously mentioned, California's diversity is a hallmark of the populations living in this state. This diversity is reflected in the State's HIV/AIDS epidemic. Identifying and overcoming barriers to care and responding to the varied and intricate service needs of special populations, especially in light of increasing case loads and reduced resources, is a challenge. There are a number of populations, which are disproportionately impacted by the epidemic, with special needs, or are typically underserved. Many recently diagnosed HIV/AIDS cases are found in communities of color, especially the African American and Latino communities, and often represent emerging populations with special needs related to initial access to care as well as ongoing care and treatment.

Although all racial and ethnic communities in California are impacted by HIV and AIDS, the composition of cases since the beginning of the epidemic is shifting. As discussed in the data above, the proportion of cases within communities of color, particularly African American and Latino communities has increased over time. In 1988, people of color comprised less than 30 percent of all new AIDS cases. By 1997, the majority of new annual AIDS cases were among people of color. Between 2001 and 2007, the number of women living with AIDS rose by approximately 37 percent compared to 30 percent for men. Females also represent a statistically significant larger proportion of living HIV than AIDS cases as of September 30, 2008, suggesting increasing rates of HIV infection among women relative to men with AIDS.

Barriers Affecting the African American Populations

African Americans face disparities in access to care and other services throughout the United States, including California. In California, they are disproportionately affected by HIV, carrying a burden of HIV disease many times larger than their presence in the

population. Based on HIV/AIDS data mentioned previously, though African Americans make up roughly 6.3 percent of the general population, they account for 18 percent of HIV/AIDS cases. In some parts of the state, such as San Francisco, African Americans are more likely than other populations to experience lower survival rates, coupled with higher rates of substance use. In California, African Americans are the population with the largest percentage of individuals living below 100 percent of the federal poverty level and are characterized by a significant level of homelessness.

Many African Americans share a cultural mistrust of the medical establishment, including clinical trials and medications. HIV-positive African American men that were ever incarcerated are often involved with substance use and high-risk sexual activity. These behaviors place them and their female partners at great risk. In the African American community, stigma is typically associated with HIV/AIDS and acts as a further barrier to serving individuals from this community. HIV is typically perceived as a disease of gay White men, contributing to denial, silence, and inaction. Additional factors such as poverty, lack of education, and cultural distrust of institutions prevent African Americans who are living with HIV or AIDS from accessing counseling and testing as well as care and treatment services.

Barriers Affecting the Latino Populations

Latinos represent a very large population group with HIV/AIDS in California, constituting 26 percent of people living with HIV/AIDS. While this is lower than their percent of the total population, Latinos are uniquely impacted by HIV/AIDS. Latinos face disparities in access to health insurance, health care, and other essentials. This results in entering treatment late in the course of the disease and experiencing other co-morbidities such as poverty and hepatitis. California is the most frequent destination of immigrants from Mexico coming to the United States. Monolingual Spanish speaking individuals face survival, language, and other adjustment challenges related to coming in to a new culture which can prevent them from accessing proper health care. Latino immigrants in California come from all parts of Latin America, Mexico, South and Central America and the Caribbean, each being culturally different. Undocumented Latinos are not eligible for most public benefits in the United States. Generational Latinos in the United States experience needs and concerns that may differ from more recent immigrants. Ongoing medical care is even more challenging for migrant workers, especially those who travel between Mexico and the United States.

For California, the proximity to the Mexican border has resulted in a large population influx of Mexican nationals as well as individuals from other parts of Central and South America. Much like border crossing zones in Texas, New Mexico, and Arizona, many immigrants travel through the California/Mexico border area on a daily basis. Some Latinos regularly travel across borders for work, family, or personal reasons while others are less transitory, remaining in the United States for longer periods of time. Eventually many Latinos remain in California on a more permanent basis. Regardless, most immigrants make these crossings back and forth across the border at least several times a year. There are minimal health services along the border, leaving many local residents without access to primary medical care.

Health care services are not well-coordinated across the border, resulting in people receiving varying levels of care and contradictory medical advice. Some Latinos prefer to access health care in Mexico, due to their familiarity with the culture of health care there. Latinos living in border areas of California, such as San Diego County, lack insurance and face language and cultural barriers to care. Border areas, especially in San Diego County experience high uninsured, unemployment and poverty rates individuals**.** Other barriers to care for Latinos include the fear of deportation related to residency status, poverty, lack of transportation, and the stigma related to HIV/AIDS. Many of these individuals face even greater stigma and service access challenges in native country. As a result, their fear of deportation is even greater and compounded by other barriers they face in accessing care and treatment.

Barriers Affecting Women, Especially Women of Color

Women are a comparatively small part of the HIV/AIDS epidemic in California, however, that proportion continues to grow. It is African American women who especially bear a disproportionate share of the epidemic among women. Women of color are among the poorest of HIV-positive clients. Women with HIV of all racial and ethnic groups may face a variety of barriers which prevent them from accessing care: serving as single heads of households, transportation challenges, and lack of childcare and medical care which does not always address the specific needs of women patients. Latina immigrants often face additional barriers, such as a cultural norm of male governance in family matters that may hinder a woman's access to care and treatment.

Perhaps because of their smaller numbers, a comprehensive continuum of care is less readily and regularly available for women than men. A comprehensive continuum of women's HIV services must include: women-focused and women-friendly primary and specialty medical care, especially in obstetrics and gynecology; family planning and prenatal care; mental health services; women-only support groups; childcare; transportation; housing; food; and access to public benefits programs. Ideally, this includes the availability of female medical and psychosocial providers from a variety of ethnic and linguistic backgrounds. Women living with HIV report frustration with doctors who did not recognize potential HIV symptoms in women, including frequent vaginal infections, or who did not recognize differences in potential medication therapies and prescriptions for women as opposed to men. Finding pre-conception counseling or an obstetrician with expertise in preventing perinatal transmission can be very difficult, especially outside of major urban areas.

Hepatitis C Identification and Surveillance

Hepatitis C is the most common blood-borne virus in the United States, with 3-4 million Americans currently infected. Injecting drugs using shared syringes or equipment is the leading cause of hepatitis C, and the majority of people who inject drugs are infected. Left untreated, hepatitis C can cause serious liver disease, including cirrhosis and liver cancer. HIV-positive persons co-infected with hepatitis C are at greater risk for liver damage from the hepatitis C virus (HCV). According to a May, 2009 report "Consequences of Hepatitis C Virus," annual medical costs for people with HCV are

expected to increase from $30 billion to more than $85 billion over the next twenty years. Medicare shows the most dramatic cost change, increasing five times from $5 billion to $30 billion. As with HIV, IDUs experience hepatitis C as a disease whose management is often complicated by stigma, criminalization and denial of basic human rights.

In California, IDUs comprise the second leading risk group for HIV infection and the majority of chronic HCV cases. According to CDPH-OA, IDU was associated with 19 percent of the 190,000 reported HIV/AIDS cases in 2009, and it is estimated that approximately 750 new HIV infections may be attributed to IDU each year. It is also estimated that 600,000 Californians are infected with HCV, and that 60 percent of those infections were acquired through IDU.

To protect individuals in SUD programs and the general public, the need to screen for HCV among SUD clients (who are not HIV positive) is growing. These numbers may underestimate the burden of hepatitis among injectors in California because IDUs access HIV counseling and testing services less frequently than individuals in other risk groups. Also, if tested for HIV, 30 percent fail to return for test results. For these individuals, HIV testing alone does not encourage IDUs and other high-risk populations to seek SUD treatment. These daunting statistics has led many California SUD programs to undertake a variety of outreach activities designed to encourage high risk drug users, including IDUs, to test for HIV. It is hoped, that once a client undertakes testing, they may be persuaded to initiate treatment. Inadequate outreach efforts, including the lack of available HCV testing, present an additional barrier to IDUs prevention and treatment needs. As data suggests, HCV testing may encourage IDUs and other high risk drug users to seek SUD treatment.

Tuberculosis (TB) Identification and Surveillance

In TB disease, living TB bacteria are present in the body and the disease is clinically active. The mode of transmission for bacilli from TB disease of the lungs or larynx's is airborne. In a SUD treatment setting, TB patients are not only more contagious and remain contagious longer, but are also more vulnerable to other infections, such as HIV. Similarly, people living with HIV are detrimentally affected when exposed to TB. In 2008, California reported 2,695 TB cases. Although the lowest rate ever reported, the rate declined from five percent a year in 2003-2006 to less than two percent in 2007, and one percent in 2008. California accounted for 21 percent of all the TB cases in the United States, the most cases reported by a state in the nation.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:
2012

End Year:
2013

Number	State Priority Title	State Priority Detailed Description
1	Increase Health Care Reform (HCR) Readiness	Health Care Reform readiness will be focused in four areas: workforce preparation; technology preparation; performance and accountability systems development; and local planning assistance.
2	Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	Develop the standards and build capacity for early intervention strategies and practices including the expansion of SBIRT into multiple settings.
3	Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Continue building local capacity and core competencies to deliver evidence based prevention strategies through improved use of the Strategic Planning Framework.
4	Ensure the SUD service system delivers culturally competent services*-Proposed	Increase readiness of SUD providers to provide culturally and linguistically appropriate services (CLAS) in accordance with the federal CLAS Standards and other cultural competence best practice models, including but not limited to, training on providing SUD services to targeted populations based on the individual needs of clients.
5	Reduce health disparities* -Proposed	Decrease disparities in treatment outcomes (NOMS) across the various population subsets including: • pregnant women, children and adolescents of substance users, underserved racial and ethnic minorities, the chronically homeless, active military personnel and veterans, individuals with co-occurring disorders (COD), intravenous drug users (IDU) and

		persons at risk for or living with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), as well as the criminal justice population.
6	Increase access to integrated services, including bidirectional integration with primary care*-Proposed	Integrate services to increase access to treatment and engage a broader array of individuals outside the traditional SUD service system. Integrated services could benefit the various population subsets including: • pregnant women, children and adolescents of substance users, underserved racial and ethnic minorities, the chronically homeless, active military personnel and veterans, individuals with COD, IDUs, and persons at risk for or living with HIV/AIDS, as well as the criminal justice population.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:
2012

End Year:
2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Increase Health Care Reform (HCR) Readiness	1.1.1: Identify a core set of outcome and performance measures and develop accountability mechanisms.	Objective 1: OARA will collaborate with other ADP divisions to develop fiscal allocation methods that reward counties who adopt evidence-based models of integrated care.	Increase the number of counties that implement the selected evidence-based models of integrated care. The measurement tool selected for this objective will be utilized to develop standardized allocation methods.	(Task 1) Evidence-based Model Selection: OARA will work with the Program Services Division to identify recommended evidence-based models of integrated care appropriate for counties to implement. (Task 2) County Allocation Development: OARA will assist PFPB to develop a standardized allocation methodology. This methodology will reward the use of evidence-based models of integrated care.
Increase Health Care Reform (HCR) Readiness	1.1.2 Identify a core set of outcome and performance measures and develop accountability mechanisms.	Objective 2: ADP will develop a list of potential data elements that could be added to CalOMS Tx to facilitate tracking of unique clients across other databases (e.g., primary care, criminal justice, employment, social services and mental health).	Increase the number of linkages to other departmental databases. This is dependent upon the number of data elements actually chosen.	(Task 1) Element and Strategy Identification:Identify data elements and strategies to facilitate linkages across multiple databases. (Task 2) CalOMS-Tx Data Element and Strategy Recommendations: Develop recommendations that facilitate database linkages and client tracking.
		Objective 3: By June		(Task 1) BHNA Review: Receive, review, and

Increase Health Care Reform (HCR) Readiness	1.1.3 Identify a core set of outcome and performance measures and develop accountability mechanisms.	2013, OARA will identify and disseminate the findings from the Behavorial Health Needs Assessment Report (BHNA) (1115 Waiver) related to service needs.	The measure is an increase in alcohol and other drugs (AOD) services that meet identified needs.	analyze completed BHNA Reports and develop key findings document. (Task 2) Key Findings Presentation: Present key findings to ADP executive staff and solicit recommendations on how to disseminate these findings to the field. (Task 3) Needs Based Services: Identify methods to assist ADP in ensuring appropriate services based on identified needs. This will include a consideration of cultural competence.
Increase Health Care Reform (HCR) Readiness	1.1.4 Identify a core set of outcome and performance measures and develop accountability mechanisms.	Objective 4: By June 30, 2013, OARA will establish benchmarks and standards for performance/outcome measures as these measures apply to HCR.	The percentage within each county meeting the performance outcome benchmarks.	(Task 1) Inter-Divisional Collaboration to Identify Various Benchmarks, Standards and Measures: By November 2011, OARA will begin work with the Performance Management Branch to identify benchmarks and standards for performance/ outcome measures as they apply to HCR. (Task 2) Cultural Competency Method Identification: Identify benchmarks and standards for culturally appropriate services. (Task 3) Outcome/Performance Presentation: Summarize and present key outcome and performance measure recommendations to executive staff. (Task 4) Provide Recommendations to AOD Field: Upon executive staff approval, OARA will work collaborately with PSD to ensure recommendations are shared with the field and implemented.
Increase Health Care Reform (HCR) Readiness	1.1.5 Identify a core set of outcome and performance measures and develop accountability mechanisms.	Objective 5: To improve the continuum of AOD services, OARA will identify epidemiologically related data systems and methods, to create outcome and performance measures.	To increase the use of data systems which contain information that is valid, reliable, accessible, current, and that are measured at the state and local level.	(Task 1) Data System Review: Review and identify epidemiologically related data systems and methods. (Task 2) Performance/Outcome Measure Determination: Determine what performance/outcome measures can be utilized by state, county, and provider entities.

Increase Health Care Reform (HCR) Readiness	1.1.6 Identify a core set of outcome and performance measures and develop accountability mechanisms.	Objective 6: By June 2014, OARA will be able to do SAS-based treatment episode analysis using CalOMS Tx data.	OARA will use episode analysis to identify longer term service utilization patterns and related outcome/performance measures to improve services. The measurement tool will be CalOMS Tx.	(Task 1) Initiate Vendor Contract: OARA will initiate a vendor contract with UCLA or other recognized expert in the field. This contract will require the development of a SAS-based episode analysis training and related training guide. (Task 2) Training Guide Creation: Receive SAS-based episode analysis training and basic guide from UCLA or other recognized expert in the field.
Increase Health Care Reform (HCR) Readiness	1.2.1 Work to improve county plans, based on the Strategic Planning Framework and HCR requirements that are developed inclusive of stakeholder input.	Objective 1: By June 30, 2013, educate, train, and encourage collaboration by counties and ADP on HCR and the Strategic Planning Framework.	1) review county evaluations on the quality of regional conferences and training provided to counties; (2) review county responses to newly developed questions for the county monitoring review tool; (3) impact of TA provided to counties by dept. SME's.	(Task 1) Identify resources and implement training and technical assistance: Follow up on the status of requests to SAMHSA for TA and assign SMEs to provideTA to counties. (Task 2) Assess readiness and identify idividual county training needs: Conduct monitoring visits and if needed refer counties to PSD/WYSB for technical assistance. Work with UCLA to sponsor statewide training. (Task 3) Sponsor county/regional meetings on HCR implementation: Convene regional workgroups and/or planning teams to include counties and local stakeholders for the purpose of planning for HCR implementation.
Increase Health Care Reform (HCR) Readiness	1.3.1 Develop AOD workforce to conform to health care reform requirements for service provisions including early intervention and reimbursement strategies for HCR related activities.	Objective 1: By October, 2011, contact Center for Medicaid Services (CMS) and participate in meetings to determine the health care reform requirements and reimbursement strategies for services performed by the SUD workforce.	ADP's increased participation on any workforce development workgroups meeting to determine the requirements of health care reform. The measurement tool will be a list of the workforce requirements for reimbursement under health care reform.	(Task 1) Contact CMS: Include ADP in any health care reform discussions of SUD treatment. (Task 2) Work with CMS to determine levels of reimbursement for SUD workforce under health care reform: Ensure our current workforce is reimbursed for services under health care reform.

Increase Health Care Reform (HCR) Readiness	1.3.2 Develop AOD workforce to conform to health care reform requirements for service provisions including early intervention and reimbursement strategies for HCR related activities.	Objective 2: By October 1, 2012, change current counselor certification regulations to reflect any changes necessary to ensure the field is prepared to meet the requirements of health care reform.	ADP will match the requirements of the field with the requirements of health care reform. The measurement tool is the alignment with state regulations and federal requirements.	(Task 1) Stakeholder collaboration to develop a regulations package to allow the current workforce to meet the requirements of health care reform: Ensure our current workforce is given the opportunity to reimburse for services under health care reform.
Increase Health Care Reform (HCR) Readiness	1.4.1 Assist counties in upgrading their IT systems to meet HCR requirements.	Objective 1: By July 1, 2011, define Electronic Health Records (EHR) standards for substance abuse organizations.	EHR standards for substance abuse organizations are defined.	(Task 1) Develop EHR Standards: In collaboration with DHCS, DMH, UCLA, counties and providers, define appropriate EHR standards for substance abuse.
Increase Health Care Reform (HCR) Readiness	1.4.2 Assist counties in upgrading their IT systems to meet HCR requirements.	Objective 2: By July 1, 2011, define health interoperability standards for substance abuse organizations.	Health interoperability standards for substance abuse organizations are defined.	(Task 1) Health Interoperability Standards: In collaboration with DHCS, DMH, UCLA, counties and providers, define appropriate health interoperability standards i.e; how providers, counties and states will communicate EHR information for substance abuse.
Increase Health Care Reform (HCR) Readiness	1.4.3 Assist counties in upgrading their IT systems to meet HCR requirements.	Objective 3: By September 1, 2011 raise awareness and educate the public regarding the availability of defined EHR and health interoperability standards to counties and providers.	58/58 Counties as well as their direct and contracted providers will be aware of EHR and health interoperability standards.	(Task 1) Health Information Technology (HIT) Communications: Develop a way to communicate health information technology standards to counties and providers. (Task 2) Bulletin of standard requirements for EHR and Interoperability: Communicate health information technology standards to counties and providers via conference call, CADPAAC announcement, bulletin, web resource, and other efforts to ensure awareness of the standards.
				(Task 1) Medi-Cal Coverage: Review federal essential health benefits for state exchanges (and Medicaid expansion populations) as they are released by the Secretary of Health & Human Services Agency to determine where SAPT BG funds can best supplement Medi-Cal

Increase Health Care Reform (HCR) Readiness	1.5.1 Re-evaluate the use of SAPT Block Grant (SAPT BG) funds as HCR impacts the SAPT BG's funds and requirements (keeping in mind Prevention and Recovery Support Services).	Objective 1: By December 31, 2012, identify uses for SAPT BG funds to support SUD treatment & prevention activities not covered by the ACA.	Statewide surveys to create a SUD benefit matrix that incorporates existing Medi-Cal benefits, the yet to be determined essential health benefits for state exchanges & Medicaid expansion populations, and ancillary services permissible under SAPTBG funding	benefits. (Task 2) Recovery Support Service Options: Evaluate potential supportive service options and for each identify barriers to implement, costs, and likely outcomes. Potential services include: *Transportation to and from treatment, recovery support activities, employment, etc.; *Employment services and job training; *Case management and individual services coordination, providing linkages with other services (e.g., legal services, Temporary Assistance for Needy Families, social services, food stamps); *Outreach; *Relapse prevention; *Housing assistance and services; *Child care; *Family/marriage education; *Peer-to-peer services, mentoring, and coaching; *Self-help and support groups (e.g., 12-step groups, SMART Recovery®, Women for Sobriety); *Life skills; *Spiritual and faith-based support; *Education; *Parent education and child development; and *Substance abuse education. (Task 3) Recovery Support Service Options: ADP will request that SAMHSA make a formal determination if SAPT BG funds may be used for the supportive service options identified in Task 2. (Task 4) Supportive Services Needs: ADP will survey each county, utilizing the County Monitoring Instrument, in order to determine demand for supportive services by service type, in each county. (Task 5) Supportive Services Advocacy: ADP anticipates that it will provide technical assistance to promote recovery supportive services for a minimum of five counties.

Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	2.1.1 Develop the protocol and standards for early intervention strategies/practices.	Objective 1: By 11-15-11 Convene a SBIRT Workgroup comprised of subject matter experts involved in the SAMHSA SBIRT Grant. The workgroup will provide recommendations on evidence based best practices in early intervention protocols and standards for use with target populations.	The Workgroup will identify and develop early intervention protocols suitable for use with adolescents, pregnant women and ethnic minorities.	(Task 1) Identify culturally competent screening and assessment tools: Convene a workgroup of SBIRT subject matter experts to identify the screening and assessment tools that are most culturally competent with target populations. (Task 2) Identify evidence based best practices that interface with tools identified in Task 1: Based on findings in Task 1, the workgroup will provide recommendations on screening and assessment tools and exam how these tools interface with existing evidence-based practices. These findings will serve as the foundation for establishing evidenced-based best practices and standards. (Task 3) Develop standards and practices based on findings of Task 2: Workgroup in collaboration with ADP will develop evidence-based best practices and standards and based on findings of Task 2.
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	2.1.2 Develop the protocol and standards for early intervention strategies/practices.	Objective 2: Collaborate and disseminate the newly developed evidence based best practices and standards at trainings conducted by the State Medical Director (SMD).	Track the number of trainings delivered and the number of participants.	(Task 1) Disseminate evidence based best practices and standards developed by Workgroup: Collaborate with SMD on trainings and disseminate evidence based best practices and standards. (Task 2) Examine lessons learned: Examine the lessons learned during conducted trainings and make any necessary adaptations (Task 3) Broad dissemination: Develop a communication plan utilizing traditional dissemination methods and social media designed to promote evidence based practices and standards to SUD and primary care providers.
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	2.2.1 Expand Early Intervention services such as SBIRT into multiple settings.	Objective 1: Utilize the State Medical Director (SMD) contract to conduct at least five SBIRT training sessions in various areas of the state so that at least 200 individuals receive the training.	Success will be measured by the number of individuals who receive SBIRT trainings.	(Task 1) Contact the SMD to determine interest and capability to conduct trainings. (Task 2) Identify the amount of SMD contract funds necessary to conduct trainings: Develop scope of work and establish terms based on available funding. (Task 3) Identify SBIRT training sites: Examine potential sites and determine which sites will be most cost-effective based on number of attendees and statewide needs. (Task 4) Facilitate SBIRT trainings.
				(Task 1) Contact the California Primary Care Association (CPCA) and advise of the upcoming

Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	2.2.2 Expand Early Intervention services such as SBIRT into multiple settings.	Objective 2: Facilitate Expansion of SBIRT Services within Community Clinics.	Expansion of SBIRT services in community clinics will be measured by the number of individuals referred to County Alcohol and Drug Services from Community Clinics.	SBIRT trainings. Discuss CPCA announcing that clients needing referrals for SUD treatment should be directed to county SUD services. (Task 2) Work with the CPCA to develop a standardized referral form for referring clients receiving SBIRT services needing referrals to specialty SUD treatment. (Task 3) Work with CADPAAC representatives to develop a mechanism to track clients referred to treatment from Community Clinics.
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	2.2.3 Expand Early Intervention services such as SBIRT into multiple settings.	Objective 3: Amend SAPT BG to allow funding for SBI services within county health systems and FQHC's.	SAPT BG will provide funding for SBI services at counties SUD treatment systems and FQHC's.	(Task 1) Work with OGM to pursue BG amendment. (Task 2) Develop necessary ADP Bulletins to advise field of new program and fiscal policies: Establish an internal workgroup charged with examining and amending existing fiscal and program policies to support utilizing new funding stream, e.g., coding on cost reports.
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	2.2.4 Expand Early Intervention services such as SBIRT into multiple settings.	OBjective 4: Amend SAPT BG to allow funding SBI service providers for referrals from primary care service delivery systems to SUD specialty services.	SAPT BG will provide funding for SBI service providers for referrals from primary care providers to SUD treatment provider network.	(Task 1) Work with OGM to pursue BG amendment. (Task 2) Develop necessary ADP Bulletins to advise field of new program and fiscal policies: Establish an internal workgroup charged with examining and amending existing fiscal and program policies to support utilizing new funding stream, e.g., coding on cost reports.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.1.1 Improve the use of the Strategic Planning Framework (SPF) at the state and local levels.	Objective 1: By September 30, 2012, ensure 100% of the 22 counties serving 90% of CA's population are addressing federal and state priorities.	The 22 counties identified as serving 90% of CA's population will include federal and state priorities, with goals, objectives and desired outcomes, in their SPF plan.	(Task 1) Identify Top Statewide Priorities: Using county SPF plans, statewide assessment data, and SAPT Block Grant application, identify 1-2 target populations with the greatest risk factors for AOD misuse/abuse (including tribal and military family youth. (Task 2) Develop Goals and Define Outcomes: Work with the CADPAAC/ADP Prevention Committee to develop goals and define desired outcomes for the identified priorities. (Task 3) Formal Adoption of Statewide Outcomes by Counties: Ensure counties formally adopt identified goals, objectives and outcomes; assist counties with incorporation in their SPF Plans, implementation using evidence-based or proven successful programs, and evaluation of results. (Task 4) Identify Partnerships to Address

				Targeted Populations: Work with counties to identify partnerships to address identified priorities.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.2.1 Build workforce capacity based on core competencies for prevention practices.	Objective 1: By July 1, 2012, develop a model for a training series on professional standards & competencies for substance abuse prevention work, to include a comprehensive outline and a piloting of the first 5 courses.	Pilot training in 5 geographic areas, with at least 10 people each area.	(Task 1) Produce course outline: Produce a comprehensive outline vetted by field experts that is in-line with CSAP, IC&RC, and SPF. (Task 2) Develop course delivery method: Develop method for delivery for web-based courses, including platform, portal and software. (Task 3) Peer review process: Develp system for peer review of courses. (Task 4) Develop 5 courses: Identify/develop 5 courses for web-based training, to include powerpoint and scripted notes transitioned to streaming web format (develop in phases). (Task 5) Pilot 5 courses: Pilot 5 selected courses through web-based platform, with a staggered release, and have pre-selected audience to provide input for potential modifications. (Task 6) Explore Integration of Training Series for Attaining Prevention Specialist Certification through IC&RC: Cordinate with CAADAC, CA's certifying body, that training series courses will meet the quality criteria for inclusion as an acceptable course towards an individual's certification.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.2.2 Build workforce capacity based on core competencies for prevention practices.	Objective 2: By July 1, 2013, a full training series on professional standards and competencies for substance abuse prevention will be available to counties and prevention providers.	Trainings will be accessed by at least 20 counties and 20 CBOs.	(Task 1) Launch Full Training Series: Complete final edits from pilot; develop learning platform with tracking features and testing capacity; complete development of courses as reflected in course outline. (Task 2) Market Training Series: Ensure that those doing substance abuse prevention work are informed of the new training series through a variety of marketing strategies.
Employ more science-based, population level				(Task 1) Optimize Health Reform Opportunities: Work within avenues set forth through health

Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.2.3 Build workforce capacity based on core competencies for prevention practices.	Objective 3: By July 1, 2013, work across systems to establish substance abuse training as a priority, especially in the area of health.	Substance abuse prevention will be integrated into the broader prevention framework within health reform and other cross disciplines.	reform policy to offer training opportunities to those in helath care related fields who are implementing the new law. (Task 2) Integrate Substance Abuse Prevention Training into Work Places in Cross Disciplines: Integrate training series offerings into orientations and in-services offered to employees in the public and private sectors, including: public health, mental health, healthcare, and social work.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.3.1 Increase the use of evidence-based prevention strategies to achieve federal, state and local priorities.	Objective 1: By July 1, 2013, implement the Strategic Prevention Framework State Incentive Grant in 8-10 communities through 4-5 county grants to meet federal prevention priority of underage drinking.	All grantees will have approved SPF strategic plans and will be reporting service data through SPF SIG data collection tools.	(Task 1) Develop statewide strategic plan: Statewide strategic plan includes needs assessment information, community selection criteria and funding allocation methodology. (Task 2) Create and monitor Advisory Council: GPAC acts as project advisory council and will approve grant priorities, review and approve local strategic plans for EBP, and guide grant implementation. (Task 3) Implement and evaluate Subrecipient projects: Create and monitor subrecipient implementation of the SPF SIG; increase SEW activity focused on local data sources; monitor PIRE's work with counties; and participation in cross site evaluation. (Task 4) Disseminate SPF SIG project findings statewide: Institute peer learning forums and other technical assistance and training opportunities to share information and findings on SPF SIG project.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.4.1 Identify new sources of funding to advance prevention efforts.	Onjective 1: By November 1, 2011, facilitate the Prevention Symposium for identified state level agencies and health-related CBOs to include AOD prevention in the health and wellness movement to leverage resources.	Prevention Symposium is held ; 3 - 5 new partners are engaged for advancing AOD prevention.	(Task 1) Plan Symposium: Work with CPI & Prevention Institute to develop participant list, agenda & desired outcomes. (Task 2) Implementation of Symposium: Hold 6 hour Symposium with participants and reach desired outcomes. (Task 3) Symposium Follow up: Per Symposium decisions, continue to work with participants to promote AOD in wellness activities.
Employ more				

science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.4.2 Identify new sources of funding to advance prevention efforts.	Objective 2: By November 30, 2011, Prevention will have 3 operational social media tools to increase outreach, feedback and virtual communities.	Social media sites are operational and the number of "followers" increase 5% each month.	(Task 1) Gain Executive Approval: Gain approval from Prevention Asst. Deputy, PSD Division Deputy, CIO and ADP Acting Director. (Task 2) Develop/implement social media: Develop and implement social media tools and content.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.4.3 Identify new sources of funding to advance prevention efforts.	Objective 3: By July 31,2012, establish new collaborative partnerships across systems for the promotion of AOD prevention efforts.	Two new partnerships are developed.	(Task 1) Explore new partnerships: Outreach to federal and state agencies, CBOs and NGOs to explore common prevention goals and share information (e.g. FQHC's, school based health clinics). (Task 2) Collaborate with new partners: Seek their assistance and provide assistance to promote shared goals and identify potential resources.
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	3.4.4 Identify new sources of funding to advance prevention efforts.	Objective 4: By December 1, 2011, identify and disseminate new sources of Prevention funding to AOD community through social media.	Number of followers receiving information increases by 5% each month.	(Task 1) Identify Funding Streams: Regularly search federal Health & Human Services webpages, grants.gov and various funder webpages for AOD and wellness grants. (Task 2) Post Action Alerts: Post when new grants are released, awards are made and technical assistance for grants are scheduled
Ensure the SUD service system delivers culturally competent services*-Proposed	4.1 To Be Determined-See Footnote 2	To Be Determined-See Footnote 2	To Be Determined-See Footnote 2	To Be Determined-See Footnote 2

Reduce health disparities*-Proposed	5.1 To Be Determined-See Footnote 2	To Be Determined-See Footnote 2	To Be Determined-See Footnote 2	To Be Determined-See Footnote 2
Increase access to integrated services, including bidirectional integration with primary care*-Proposed	6.1 To Be Determined-See Footnote 2	To Be Determined-See Footnote 2	To Be Determined-See Footnote 2	To Be Determined-See Footnote 2

Footnotes:

1.) Numbering System: First Number=Priority Area; Second Number=Goal; Third Number=Strategy/Objective.

2.) ADP currently awaits the completion of the California's Medi-Cal (Medicaid) Section 1115 Behavioral Health Needs Assessment. While focusing on Medi-Cal beneficiaries, the1115 waiver's needs assessment may contain pivotal information that will help California fill in gaps in the data and literature relating to its overall behavioral health system. This additional information will allow ADP to more effectively incorporate the needs and priorities of special populations, the changing health care environment, and SAMHSA's strategic initiatives into its existing SNAP process. For these reasons, ADP has not yet developed objectives and performance indicators with respect to priorities 4, 5 and 6. Based upon ADP's significant experience and solid framework from which to approach these priorities, once the 1115 waiver's needs assessment is complete, ADP will be capable of quickly and strategically refining them.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy
Grant/contract reimbursement	University of California, San Francisco (UCSF) provides a licensed physician (serving as Medical Director), a Research Assistant, and a Consultant to provide consultations for implementation of State and federal laws and regulations, and to provide the medical expertise necessary to complete ADP's mission and strategic vision. Specific services provided are shown in the footnotes. ONTRACK Program Resources, Inc., assists ADP in providing culturally and linguistically appropriate services (CLAS) in accordance to CLAS standards and other cultural competence best practice models. Specific services provided are shown in the footnotes.
Innovative Financing Strategy	The full range of substance use disorder services paid for with SAPT Block Grant funds, including: •Outpatient Individual and Group Counseling •Day Care Rehabilitative (intensive outpatient counseling) •Perinatal Residential •Narcotic Replacement Therapy

Footnotes:

(UCSF)
1.Provides input on current issues in California and nationally on drug and alcohol misuse, misuse of legal medications, co-occurring substance disorder-mental health issues, medical issues and other health-related issues as they relate to the use/misuse of substances.
2.Advises on evidence-based services including medication-assisted treatment and psychosocial interventions related to effective treatment of substance use disorders (SUD).
3.Assists with workforce development issues, the development of treatment standards including written materials, and identify experts for panels and taskforces convened by ADP on specific SUD issues.
4.Assists with the integration of SUD treatment services into mental health and other healthcare facilities including primary care programs, hospital-based settings, outpatient clinics and other medical settings as requested.
5.Provides consultation to stakeholders in developing and implementing programs that will deliver integrated treatment services in California by developing written materials, and direct teaching, as requested by ADP.
6.Provides services for preparing the substance use disorder field, including counties and providers, for implementation of the federal Patient Protection and Affordable Care Act (aka health care reform). Areas for consultation may include: California's existing Section 1115 Medicaid demonstration waiver, the health care needs of the Medicaid expansion population, essential health benefits for SUD in Medicaid, person-centered medical home concepts, linkages with federally qualified health centers and other clinics, and identifying best practices for integration.
7.Represents ADP with county, state and federal leaders in health care. For example: county alcohol and drug administrators, county medical directors, multi-specialty clinic medical directors, community-based clinics, professional medical associations, the State Medicaid Director, chairs of the State Legislature's Health Care Committees, the new California Health Benefit Exchange Board, and the federal Health Resources and Services Administration (HRSA).
8.Provides services required of ADP by Senate Bill 1441 (Chapter 548, Statutes of 2008) to include ongoing participant with the Department of Consumer Affairs related to development and implementation of monitoring standards for healthcare professionals with SUDs.
9.Provides in-service training to ADP workforce on specific content areas in the field as requested by ADP.
(ONTRACK)
1.Assesses alcohol and other drug (AOD) agencies' readiness and ability to provide culturally and linguistically appropriate services (CLAS) in accordance with the CLAS Standards and other cultural competence best practice models.
2.Provides statewide cultural competence training and TA that enhances AOD agency staff competencies in services to targeted populations such as gender, disability, ethnicity, veterans, Lesbian, Gay, Bisexual, Transgender, and other target populations.
3.Develops and disseminates CLAS guidelines that identify and document evidence-based and best practice models for cultural and linguistic competency for AOD agencies.
4.Develops and implements statewide marketing strategies to inform the AOD treatment and recovery field of the Contractor's services to assure statewide access and service.
5.Serve as a clearinghouse for research and resources on evidence-based and promising practice models in cultural competence related to the provision of AOD services and improving client outcomes.
6.Evaluate performance in meeting the overall contract goal of improving CLAS and client outcomes among AOD agencies.

See Attachments Exhibit A for additional information

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2012

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	N/A 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	26-50% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	N/A 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	N/A 6
System improvement activities		<10% 6
Other		N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year: 2012

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$0	$0	$0	$0
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$9,848,995	$	$	$	$
Information Dissemination	Total	$9,848,995	$0	$0	$0	$0
Education	Universal	$	$0	$0	$0	$0
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$12,369,427	$	$	$	$
Education	Total	$12,369,427	$0	$0	$0	$0
Alternatives	Universal	$	$0	$0	$0	$0
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$7,727,547	$	$	$	$
Alternatives	Total	$7,727,547	$0	$0	$0	$0
Problem Identification and Referral	Universal	$	$0	$0	$0	$0
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$1,483,636	$	$	$	$
Problem Identification and Referral	Total	$1,483,636	$0	$0	$0	$0

Community-Based Process	Universal	$	$ 0	$ 0	$ 0	$ 0
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$ 12,413,393	$	$	$	$
Community-Based Process	Total	$12,413,393	$0	$0	$0	$0
Environmental	Universal	$	$ 0	$ 0	$ 0	$ 0
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$ 4,042,793	$	$	$	$
Environmental	Total	$4,042,793	$0	$0	$0	$0
Section 1926 Tobacco	Universal	$	$ 0	$ 0	$ 0	$ 0
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$ 2,000,000	$	$	$	$
Section 1926 Tobacco	Total	$2,000,000	$0	$0	$0	$0
Other	Universal	$ 0	$	$ 0	$ 0	$ 0
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$ 3,385,496	$	$	$
Other	Total	$0	$3,385,496	$0	$0	$0

Footnotes:

Beginning with FFY 07, other federal is comprised of discretionary grants and is not part of the cost report process. Therefore, categorical expenditures are not noted.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$181,861,723	$207,611,313	$5,910,665	$415,975,145	$	$
2. Primary Prevention	$49,885,791	$	$3,385,496	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$12,471,448	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$5,209,994	$	$853,839	$6,718,105	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$249,428,956	$207,611,313	$10,150,000	$422,693,250	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$5,209,994	$	$853,839	$6,718,105	$	$
11. Total	$249,428,956	$207,611,313	$10,150,000	$422,693,250	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year: 2012

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment		$		$ 358,432		$358,432
2. Quality Assurance		$		$ 574,394		$574,394
3. Training (Post-Employment)		$		$ 234,607		$234,607
4. Education (Pre-Employment)		$		$		$
5. Program Development		$ 956,000		$ 1,599,044		$2,555,044
6. Research and Evaluation		$		$ 661,280		$661,280
7. Information Systems		$		$ 270,000		$270,000
8. Total	$	$956,000	$	$3,697,757	$	$4,653,757

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

California has a long-standing commitment to promoting client directed services. In 2006, California commenced a task force of members representing a wide array of specialties within the alcohol and other drug (AOD) addiction field to address problems within the system of care and recommend improvements. The task force created a report, *ADP Continuum of Services System Re-Engineering (COSSR)* that includes the section, Prevention and Recovery Support Services, which speaks to the need to promote client directed services and is described further in the following goal:

> *Goal: Empower and prepare individuals and communities to prevent, reduce, or manage their AOD risks and recovery.*
>
> The Continuum of Services (COS) model should promote and facilitate effective self-management support strategies at individual and community levels and engage those individuals in the prevention and in the recovery system as partners, integral to the COS.
>
> Prevention reduces the probability of developing or exacerbating direct and/or indirect personal, social, health, and economic problems resulting from problematic ATOD availability, manufacture, distribution, promotion, and sales, as well as individual use. The desired result is to promote safe, healthy behaviors and environments for individuals, families, and communities.
>
> Successful treatment outcomes depend to a significant degree on the effectiveness of self-management. Effective self-management in recovery acknowledges the communities' and individuals' central role in aftercare. The system of services must empower and prepare individuals to manage their recovery and health care by using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up; and by organizing internal and community resources to provide ongoing self-management support to individuals.
>
> Using a collaborative approach, providers, communities, and individuals must work together to define problems, set priorities, establish goals, create recovery plans and solve problems along the way. These "productive interactions" between providers and individuals need not be restricted to face-to-face visits, nor necessarily to one-on-one encounters. Self-management support using group visits and telephone follow-up are evidence-based examples of new methods of making communication between individuals and providers both more efficient and more useful to the individual.
>
> Objective 1: Provide outreach services to persons and their significant others who may or may not have gone through formal treatment and/or who may benefit from recovery support services.
>
> Objective 2: Require ADP to take leadership in creating and implementing a recovery management system.

Objective 3: Assure that prevention practices and services include community-based approaches, policies, procedures, and program approaches that are evidence-based and culturally competent.

Objective 4: Increase availability of an array of housing for sober and transitional-living communities.

Objective 5: Organize culturally appropriate community resources to provide ongoing self-management support to individuals and communities to effectively reduce their risk of AOD problems.

Objective 6: Assure that cultural competency is integrated in community-based prevention and recovery support services.

This material continues to be promoted by ADP and its executive staff internally and externally at conferences, quarterly meetings with County Alcohol and Drug Administrators, and through a contract with the University of California, Los Angeles (UCLA) to provide service improvement training and technical assistance (TA) to counties and providers.

Additionally, the Office of Women's and Perinatal Services managed a 3 year contract to provide training and technical assistance to providers in California that treat pregnant and parenting women as well as women who do not have children. The training was a series of classes at various locations across the state. The classes were taught by Dr. Stephanie Covington, who is a clinician, author, organizational consultant, and lecturer recognized for her pioneering work in the area of women's issues and specializes in the development and implementation of gender-responsive services. An important part of Dr. Covington's curriculum is the emphasis of the importance that client services be client directed.

Furthermore, many recovery support services available to clients in California are self directed, such as the Alcoholics Anonymous 12-step program and Al-Anon.

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

The California Department of Alcohol and Drug Programs (ADP) has data systems that are designed to meet the data collection and reporting systems necessary to respond to the reporting requirements for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, Health Insurance Portability and Accountability Act, and the Access to Recovery Grant. The data systems are the following:

- California Outcomes Measurement System for Treatment (CalOMS Tx),
- CalOMS Prevention (CalOMS Pv),
- Drug and Alcohol Treatment Access Report (DATAR)
- Net Negotiated Amount and Drug Medi-Cal contract and cost reporting system (NNA/DMC),
- Master Provider File (MPF)
- Short-Doyle Medi-Cal ADP Remediation Technology (SMART),
- California Access to Recovery Effort (CARE).

ADP developed the Short-Doyle Medi-Cal ADP Remediation Technology (SMART) system as part of a larger project with the Department of Health Care Services (DHCS), which is the single state agency for Medicaid programs in California, and the Department of Mental Health (DMH). The purpose of the project was to ensure that all data systems that manage Medicaid payments for behavioral health services in California are fully HIPAA compliant. Currently, ADP is working with DHCS and DMH to implement the 5010 standard, which will require minimal remediation of the SMART system and more extensive enhancement for DHCS.

The CalOMS Tx system identifies clients who are publicly funded including both DMC and SBG. Data from CalOMS Tx and the SMART system are used to project annual Drug Medi-Cal (DMC) caseloads and a variety of other reports. Data from the NNA/DMC contract and cost report system are used for establishing DMC rates annually.

CalOMS-Pv does not use a unique identifier for individuals but does collect information on age, race/ethnicity, and gender for individual-based prevention services. For population-based prevention services (all services under Information Dissemination and most services under Community-Based Process and Environmental), ADP found that providers were unable to identify the number or demographics of the individuals served. Therefore, CalOMS Pv was designed to track the number of services provided and/or number of items distributed rather than the number of individuals served. For all other demographic-type services, providers can use a summary of demographics or identify individuals. Providers are encouraged to utilize a code or initials rather than an individuals name. Individual participant data is only available to the provider entering the data – it cannot be viewed at either the county or state level.

The State of California has received a $1 million Exchange Planning and Establishment Grant, to be used to develop a detailed business and implementation plan leading up to the 2014 operation of the California Exchange. The grant enables California to accomplish the following:

- Inventory and analyze existing state and local programs and resources,
- Develop appropriate workplans and timelines for Exchange implementation, and
- Begin to define the additional infrastructure, resources, data and coordination activities that will be needed to make the California Exchange operational by 2014, consistent with federal requirements and available federal funds.

ADP participates in regularly scheduled meetings conducted by DHCS to plan the operation of the California Exchange. For the immediate future, funds designated for DMC, the California substance abuse option for providing treatment for Medicaid beneficiaries, will remain separate and distinct from the exchange. The group is exploring the options for data systems, and exchange of information between the general health care data system and the Substance Use Disorder (SUD) data systems. As the federal government provides more guidance on the provision of SUD services under HCA, ADP may become more directly involved in the California Exchange.

The following table identifies the unique IT systems maintained and/or utilized by the Department of Alcohol and Drug Programs and provides the requested information about the specific data systems:

CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DATA SYSTEMS CHARACTERISTICS
FISCAL YEAR 2011-12

DATA SYSTEM	PROVIDER CHARACTERISTICS	CLIENTS ENROLLMENT, DEMOGRAPHICS, CHARACTER	ADMISSION, ASSESSMENT, DISCHARGE	SERVICES-TYPE, AMOUNT, INDIVIDUAL SERV PROV	PRESCRIPTION DRUG UTILIZATION	NPI-OBTAIN, COLLECT, RECORD	OTHER UNIQUE PROVIDER ID	UNIQUE CLIENT IDENTIFIER FOR UNDUP COUNTS & AGGREGATE SERVICE CNT	CLIENT DATA INCLUDE INDIVIDUAL ENCOUNTER	USE ICD-10 OR CPT/HCPCS CODES	PROVIDER & CLIENT IDs LINKS TO MEDICAID PROVIDER ID
California Outcomes Measurement System Treatment (CalOMS Tx) – Collects client characteristics, demographics, provider information, services, and outcomes. Source of CA data for the SAMHSA Treatment Episode Data Set (TEDS)	Y	Y	Y	P[1]	Y	Y	Y[2]	Y[3]	N	N[4]	P[4]
California Outcomes Measurement System Prevention (CalOMS Pv) – a fully web-based data collection service for primary prevention service/activity data funded with the Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars from the Department of Alcohol and Drug Programs.	Y	Y	NA[5]	P[5]	N	N	Y[2]	NA	NA	NA	NA
Drug Abuse Treatment Access Report (DATAR) – System collects, stores, and reports data regarding public treatment capacity of AOD programs contracted by counties or directly by ADP.	Y	P[6]	N[7]	P[8]	NA	N	Y[2]	NA	NA	N	Y
Negotiated Net Amount/Drug Medi-Cal Contract System (NNA/DMC) – This system provides the vehicle for managing contracts with the counties for estimated numbers of services among funded modalities. Also used for cost reporting at the end of the State Fiscal Year. Counties report, by provider, the number of services provided, and the cost of providing per unit of service. Some counties may receive SAPT, State General Fund, and various additional fund sources. The counties also report the amount of County funds committed and used. This is reported in the NNA portion of the contract. For those counties also participating in the Drug Medi-Cal Program, the DMC portion of the contract and cost report are submitted to the State also.	Y	N	N	P[9]	N	N	Y[2]	N	N[9]	N	?

LEGEND: Y=Yes; N=No; P=Partial

DATA SYSTEM	PROVIDER CHARACTERISTICS	CLIENTS ENROLLMENT, DEMOGRAPHICS, CHARACTER	ADMISSION, ASSESSMENT, DISCHARGE	SERVICES-TYPE, AMOUNT, INDIVIDUAL SERV PROV	PRESCRIPTION DRUG UTILIZATION	NPI-OBTAIN, COLLECT, RECORD	OTHER UNIQUE PROVIDER ID	UNIQUE CLIENT IDENTIFIER FOR UNDUP COUNTS & AGGREGATE SERVICE CNT	CLIENT DATA INCLUDE INDIVIDUAL ENCOUNTER	USE ICD-10 OR CPT/HCPCS CODES	PROVIDER & CLIENT IDs LINKS TO MEDICAID PROVIDER ID
Master Provider File (MPF) – Data system to track provider names, ID numbers, addresses and characteristics information for use in licensing, treatment, prevention, and fiscal management business at ADP.	Y	N	N	Y	N	Y	Y[2]	NA[10]	NA[11]	NA	P
Short-Doyle Medi-Cal Remediation Technology (SMART) – System for receiving fully HIPAA compliant Medicaid claims for AOD Treatment; transmitting to DHCS for adjudication; returning 835 to ADP; transmitting warrant request to State Controller's Office; and, resulting in payment of approved claims. ADP, DMH, and DHCS are in the processing of updating the three systems to comply with the 5010 standard.	Y	P[12]	P[12]	Y	P[12]	Y	Y[2]	Y[13]	Y[14]	Y	Y
California Access to Recovery (CARE) Voucher Management System – Data system developed and maintained by Maximus to manage the vouchers, assessments, and case management information for participants in CARE.	Y	Y	Y	Y	Y	N[15]	Y[16]	Y	Y	N	N

LEGEND: Y=Yes; N=No; P=Partial

FOOTNOTES:

[1] Collects the service type with limited amount of service information at the individual client level.
[2] ADP # = 2 digit County code (158) + sequential 4 digit number.
[3] Unique Client Identifier = Gender + Date of Birth + Current First Name + Current Last Name + Social Security Number + Zip Code at Current Residence + Birth First Name + Birth Last Name + County and State of Birth + Driver's License/State ID Card # + DL/State ID Card State Code + Mother's First Name.
[4] The SMART system, which manages the DMC claims system, is the only data system that uses ICD 9 and HCPCS codes for reporting services. We will be remediating the system to accept ICD-codes by the deadline.
[5] The system contains no individual client-specific data. Uses client summary data only for services provided in groups.
[6] Includes limited summary information regarding individuals seeking treatment.
[7] Contains limited summary information regarding individuals awaiting admission for treatment.
[8] Individuals not yet receiving treatment.
[9] Includes # of units of service provided by specific program, but not at individual client level.
[10] Describes program only, including list of services provided.
[11] Contains no client data.
[12] Only gender and DOB is required for valid DMC claim. Client characteristic data collected in CalOMS Tx.
[13] Medi-Cal # assigned by the CA Department of Social Services.
[14] Claim includes date and type of service provided.
[15] Does not currently include NPI, but may consider adding in future updates.
[16] Unique CARE ID#.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

The California Department of Alcohol and Drug Programs (ADP) is committed to addressing Continuous Quality Improvement (CQI). Examples of the quality improvement efforts at the state level include:

- ADP adheres to the Substance Abuse Prevention and Treatment (SAPT) Block Grant required independent peer review process to assess and improve the quality and appropriateness of treatment services delivered by providers that receive block grant funds. One of ADP's main goals of the peer review is to ensure that continuous quality improvement is practiced in all of its programs.

- The establishment of the Continuum of Services System Re-engineering (COSSR) Task Force to build a system of care based on the Institute of Medicine (IOM) Quality Chasm Series. The COSSR Task Force is working to move standards of care from an acute illness-based system to a chronic illness model to address the prevention, treatment, and RSS needs of consumers.

- The development of the Statewide Needs Assessment and Planning (SNAP) process to support ADP initiatives by generating data and information to facilitate departmental decision-making and operation innovations. (SNAP has been addressed further in the planning steps of the behavioral health assessment and plan within this application.)

- The draft development of *California's Best System Practices for Substance Use Conditions*, as adapted from the *National Quality Forum's National Consensus Standards for the Treatment of Substance Use Conditions.*

- The draft development of Treatment Standards for Substance Use Disorders: A Guide for Services to be Used to Enhance Current Provider Certification Standards.

In addition to the CQI efforts listed above, ADP has also developed a 2010-2012 Cultural Competency Quality Improvement (CCQI) Strategic Plan. Through an extensive and fast-track planning process, the Department adopted the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the Office of Minority Health, U.S. Department of Health and Human Services, as the guide for developing a Cultural Competency Quality Improvement Strategic Plan to support CQI in our service delivery system. This Plan supports the Department's Vision, Mission, Core Programs, overall Strategic Goals and the implementation of the COSSR Project.

CQI is addressed on an ongoing basis by ADP's Performance Management Branch, County Monitoring Unit (CMU). The CMU has primary responsibility to monitor counties' adherence to the Net Negotiated Amount (NNA) and

Drug/Medi-Cal (DMC) contract requirements and the SAPT Block Grant terms. In addition, programmatic oversight is achieved through the County Monitoring process. This is accomplished by an annual review of each County which satisfies the minimum legal and regulatory requirements for contract compliance in the Code of Federal Regulations (CFR) 45 and CFR 42.

The county monitoring process has been designed to operate in three-year cycles, all SAPT Block Grant and contract requirements are reviewed once in the three-year cycle. The monitoring instrument is revised annually to encompass different components of the requirements, as well as other programmatic areas the department deems necessary to oversee. Based on compliance rates or emphasis areas some components may be reviewed annually rather than once in the three-year cycle, however, at minimum all requirements are reviewed at least once in the three-year period of time. During the annual review process CMU collects information on the counties adherence to NNA and DMC contract requirements by administering a monitoring instrument to County Alcohol and Drug Program Administrators. The instrument elicits qualitative responses as well as certifications from County Administrators and their staff who directly oversee the provision of substance use services at the local level.

The county monitoring process improves fiscal and programmatic accountability of Counties within the state and ensures that the use of SAPT dollars is maximized by identifying barriers and implementing solutions at the local level. Through the review process monitoring analysts identify areas of deficiencies or concerns that may adversely affect alcohol and other drug (AOD) services provided within the County. Once a review has been completed, the monitoring analyst will submit a report to the county identifying highlights, findings, advisory recommendations and required follow up. The County is required to respond to the findings identified in the report by submitting a corrective action plan documenting how the findings will be rectified. It is the responsibility of the monitoring analyst to ensure that appropriate technical assistance is provided to Countiesy~~'s~~ to assist in addressing local needs.

While the County Monitoring process primarily serves to satisfy a compliance function, it also provides valuable data for program oversight and improvement as well as long term planning at the state level by providing a snapshot of the status of different components of the AOD system statewide.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

California is home to more than 150 American Indian/Alaskan Native (AI/AN) tribes, 108 of which are federally recognized sovereign nations. One of the Department of Alcohol and Drug Programs (ADP's) goals is to ensure that all Californians have access to effective services provided in a manner compatible with their cultural health beliefs and practices. While ADP has, for many years, had programs in place that seek to improve the quality and accessibility of alcohol and other drug (AOD) services available to AI/AN and solicit input from representatives of AI/AN communities on ADP policies and priorities, ADP looks forward to developing a more robust system for working with California's AI/AN communities. In doing so, ADP looks forward to establishing a system that will support regular and meaningful communication with elected tribal leaders in California.

ADP has a position serving as liaison to California's AI/AN communities. Requests made to ADP from AI/AN constituents or regarding AI/AN issues or needs are directed to the AI/AN liaison. The AI/AN liaison also coordinates ADP consultation with its AI/AN Constituent Committee, elected Tribal officials, California area Indian health boards, Southern California Tribal Chairman's Association, Tribal Health Operating Units, Single Tribe Health Clinics and Urban Health Programs.

ADP's AI/AN Constituent Committee offers ADP advice on ways to improve and expand AOD services to California's AI/AN population. The Committee consists of up to twelve representatives selected for their involvement in the AI/AN community, knowledge of alcohol and other drug prevention, treatment and recovery services and the unique needs of the communities within the region of the state which they represent. The Committee offers ADP input on issues and concerns within the California AI/AN Communities, and the Committee is asked for input when ADP proposes significant policy changes which may impact services to the AI/AN communities.

The Chair of ADP's AI/AN Constituent Committee additionally serves on ADP's Director's Advisory Council (DAC). The DAC members represent alcohol and drug program leaders, judges, directors of provider organizations, AOD educational organizations and/or Counselor Certification Organizations, the County Alcohol and Drug Program Administrator's Association of California and ADP's eight constituent committees. The DAC is intended to be responsive to critical issues from the larger AOD field, identify barriers to access for unserved/underserved populations and provide feedback to the organizations and communities represented.

ADP will be expanding its system for consulting with California AI/AN communities in several ways. One of these will be by inviting California's elected tribal officials to participate in ADP advice seeking and information sharing activities. ADP will work with the Pacific Regional Office of the federal Bureau of Indian Affairs to obtain a list of California elected tribal leaders so that these leaders may be notified of upcoming DAC meetings and welcomed to attend. As ADP proposes significant policy changes and/or shares important updates on activities taking place within the AOD field, ADP will work with key health care and tribal stakeholders to participate in meetings that convene all elected tribal leaders.

California statute (Health and Safety Code Section 11814) requires ADP to allocate State and federal AOD treatment and prevention funds based on the population of each county. Counties receiving SAPT Block Grant allocations will be asked to annually assess the alcohol and other drug prevention, treatment and recovery service needs of the AI/AN communities within their district. These counties will be asked to develop, and submit to the state for review and approval, a plan for addressing the identified needs of AI/AN communities within their district. Counties will also need to describe their system for ongoing consultation with the Tribal governments within their county, specifying the names and contact information of the elected tribal leaders with whom they will collaborate.

ADP has a technical assistance (TA) and training contract to improve alcohol and other drug prevention, treatment and recovery services provided to AI/AN Californians and to expand California AI/AN community awareness of available AOD services. The nature and quantity of training requests and data received through pre- and post-evaluations assist the contractor in establishing a baseline understanding of the AOD service needs of Native Americans in California.

In 2010, ADP required bidders competing for its renewed AI/AN TA contract to perform an assessment of the current need for ADP services within California's AI/AN population and to describe how, utilizing evidence-based practices, strategies or approaches, they would address the identified needs. In November 2011, the awarded contractor, the Oakland AI/AN Health Center, will be submitting the first of three annual reports describing the effectiveness of the contractor's solution(s) to reducing systemic, programmatic and fiscal barriers to prevention, treatment and recovery of ADP problems. The reports will also provide an update on the identified gaps in ADP services by county or geographic area.

At the state level, California Outcomes Measurement System-Treatment (CalOMS-Tx) data is collected on individuals who self-identify as AI/AN and request treatment from publicly funded providers. Data collected from SAPT Block Grant providers and input received from the AI/AN Constituent Committee and technical assistance provider is included in ADP's Statewide Needs Assessment and Planning (SNAP) process. Additionally, the State Epidemiological Outcomes Workgroup is examining appropriate data sources to better inform the needs assessment pertaining to California AI/AN communities.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

Process State employs to identify trends in over/under utilization

All providers of publicly funded substance abuse treatment services are required to report data as requested by ADP. The California Outcome Measurement System for treatment (CalOMS-Tx) is the primary vehicle used to collect client level treatment data. The general strategy for client data submission is for providers to submit their client data to their respective County Alcohol and Other Drug agencies. The County AOD's, in turn, submit the data to ADP. A variety of information systems are used to accomplish the coordination of this task. Some providers enter their data directly into CalOMS-Tx through a web-based portal. Other providers enter the data into their agency information system from which the agency transfers an extract into CalOMS-Tx. Client data must be submitted to ADP within 45 days after the end of the month in which the service was performed. The ADP monitors providers and counties' CalOMS-Tx Reporting, specifically:

- Percent of late data submissions (with a standard of shall not exceed 5 percent for any report month)
- Percent of records rejected (with a standard of shall not exceed 5 percent for any report month)
- Ensuring that new county and provider staff are trained in CalOMS-Tx use
- Use of Web-based CalOMS-Tx training
- Monthly review of CalOMS-Tx Data Quality Compliance Report
- Existence of any significant barriers to data reporting
- Training on collection of admission and discharge data
- Ensuring that narcotic treatment programs (NTP) enter type of medication
- Ensuring that providers collect data for all clients
- Indicating if a county desires Technical Assistance (TA)

In addition, ADP maintains the Web-based Drug and Alcohol Treatment Access Report (DATAR) data system that can be used to monitor the statewide treatment capacity of funded providers. County authorities and providers use DATAR data to monitor capacity, utilization, and wait list status of providers. ADP maintains a dedicated DATAR email box to assist counties in resolving questions and concerns about DATAR reporting and to allow for TA as requested.

It is important to note that the State has articulated a need for assistance regarding the Web-based DATAR system. Assistance is needed in clarifying reporting definitions since a significant number of providers have different interpretations and/or understanding of the definitions. This is especially true for outpatient services regarding capacity reporting. The Center for Substance Abuse Treatment (CSAT) State Project Officer (SPO) and the State agreed to discuss this need for assistance more fully to determine how best to meet the need.

Most utilization management efforts are conducted at the county authority level.

Strategies State will deploy to address these utilization issues

ADP's Office of Applied Research and Analysis (OARA) utilizes CalOMS-Tx treatment data for preparation of internal and external reports, as well as for reporting TEDS/NOMs and providing data for the SAPT Block Grant application. Additionally, OARA compares data between State Fiscal Years, to determine if there is significant change in service utilization (and/or reporting). Upon determination that there is a difference (+/- 10%), Information Management Services Division (IMSD) staff contacts the counties in question to determine if there is a need for TA to input data, if there are training needs, or if there has been a significant reduction or addition to staffing with the resultant reflection in treatment rates.

When a determination is made that DATAR data has not been received, IMSD contacts the county or provider in question to determine if there is a need for TA or if there are training needs.

Intended results of utilization management strategies

The intended results of utilization management strategies, both for CalOMS-Tx and for DATAR are improved reporting and compliance.

Resources needed to implement these strategies

While the onus for reporting is on the counties and providers, ADP does monitor CalOMS-Tx and DATAR as fully and completely as possible with the limited staff resources available. To further improve reporting and compliance efforts, IMSD will seek redirection of an internal staff position.

Proposed timeframes for implementing these strategies

These strategies and efforts are ongoing and in place currently. They will be further enhanced when an internal staff position can be redirected to IMSD.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2012

Priority	Performance Indicator	Selected
Increase Health Care Reform (HCR) Readiness	Increase the number of counties that implement the selected evidence-based models of integrated care. The measurement tool selected for this objective will be utilized to develop standardized allocation methods.	é
Increase Health Care Reform (HCR) Readiness	Increase the number of linkages to other departmental databases. This is dependent upon the number of data elements actually chosen.	é
Increase Health Care Reform (HCR) Readiness	The measure is an increase in alcohol and other drugs (AOD) services that meet identified needs.	é
Increase Health Care Reform (HCR) Readiness	The percentage within each county meeting the performance outcome benchmarks.	é
Increase Health Care Reform (HCR) Readiness	To increase the use of data systems which contain information that is valid, reliable, accessible, current, and that are measured at the state and local level.	é
Increase Health Care Reform (HCR) Readiness	OARA will use episode analysis to identify longer term service utilization patterns and related outcome/performance measures to improve services. The measurement tool will be CalOMS Tx.	é
Increase Health Care Reform (HCR) Readiness	1) review county evaluations on the quality of regional conferences and training provided to counties; (2) review county responses to newly developed questions for the county monitoring review tool; (3) impact of TA provided to counties by dept. SME's.	é
Increase Health Care Reform (HCR) Readiness	ADP's increased participation on any workforce development workgroups meeting to determine the requirements of health care reform. The measurement tool will be a list of the workforce requirements for reimbursement under health care reform.	é
Increase Health Care Reform (HCR) Readiness	ADP will match the requirements of the field with the requirements of health care reform. The measurement tool is the alignment with state regulations and federal requirements.	é
Increase Health Care Reform (HCR) Readiness	EHR standards for substance abuse organizations are defined.	é
Increase Health Care Reform (HCR) Readiness	Health interoperability standards for substance abuse organizations are defined.	é

Increase Health Care Reform (HCR) Readiness	58/58 Counties as well as their direct and contracted providers will be aware of EHR and health interoperability standards.	
Increase Health Care Reform (HCR) Readiness	Statewide surveys to create a SUD benefit matrix that incorporates existing Medi-Cal benefits, the yet to be determined essential health benefits for state exchanges & Medicaid expansion populations, and ancillary services permissible under SAPTBG funding	
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	The Workgroup will identify and develop early intervention protocols suitable for use with adolescents, pregnant women and ethnic minorities.	
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	Track the number of trainings delivered and the number of participants.	
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	Success will be measured by the number of individuals who receive SBIRT trainings.	
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	Expansion of SBIRT services in community clinics will be measured by the number of individuals referred to County Alcohol and Drug Services from Community Clinics.	
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	SAPT BG will provide funding for SBI services at counties SUD treatment systems and FQHC's.	
Build the Alcohol and Other Drugs System capacity for Early Intervention (EI) strategies, such as SBIRT.	SAPT BG will provide funding for SBI service providers for referrals from primary care providers to SUD treatment provider network.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	The 22 counties identified as serving 90% of CA's population will include federal and state priorities, with goals, objectives and desired outcomes, in their SPF plan.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Pilot training in 5 geographic areas, with at least 10 people each area.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Trainings will be accessed by at least 20 counties and 20 CBOs.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Substance abuse prevention will be integrated into the broader prevention framework within health reform and other cross disciplines.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	All grantees will have approved SPF strategic plans and will be reporting service data through SPF SIG data collection tools.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Prevention Symposium is held ; 3 - 5 new partners are engaged for advancing AOD prevention.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Social media sites are operational and the number of "followers" increase 5% each month.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Two new partnerships are developed.	
Employ more science-based, population level Prevention (Pv) Strategies and identify new funding or resource strategies to expand evidence-based prevention activities in California.	Number of followers receiving information increases by 5% each month.	
Ensure the SUD service system delivers culturally competent services*-Proposed	To Be Determined-See Footnote 2	
Reduce health disparities*-Proposed	To Be Determined-See Footnote 2	
Increase access to integrated services, including bidirectional integration with primary care*-Proposed	To Be Determined-See Footnote 2	

Footnotes:

The California Department of Alcohol and Drug Programs (ADP) currently awaits the completion of California's Medi-Cal (Medicaid) Section 1115 Behavioral Health Needs Assessment. While focusing on Medi-Cal beneficiaries, the1115 waiver's needs assessment may contain pivotal information that will help California fill in gaps in the data and literature relating to its overall behavioral health system. This additional information will allow ADP to more effectively to incorporate the needs and priorities of special populations, the changing health care environment, and SAMHSA's strategic initiatives into its existing State Needs Assessment and Planning (SNAP) process. For these reasons, ADP has not yet developed objectives and performance indicators with respect to priorities 4, 5 and 6. Based upon ADP's significant experience and solid framework from which to approach these priorities, once the 1115 waiver's needs assessment is complete, ADP will be capable of quickly and strategically refining them.

Throughout this application, ADP believes it has illustrated a solid foundation that includes system-wide improvement efforts through our Continuum of Services System Re-engineering (COSSR) and SNAP from which to move forward. ADP has also demonstrated a strong history in working with a variety of special populations. For example, its:

- technical assistance (TA) on trauma-informed and gender-specific care for women;
- new multi-year CLAS initiative to provide cultural competency TA to the substance use disorder (SUD) field; and
- active membership in the State Interagency Team (SIT) for children, youth, and families.

These are but a few of the statewide efforts ADP has launched and/or participated in. These and numerous other efforts described within this application serve as the springboard for ADP's ongoing work in ensuring culturally competency, reduced health disparities and improved access to SUD services among its special populations.

Additionally, as a component of a contract that ADP entered into with the University of California, Los Angeles (UCLA), draft dashboard templates have been developed for consideration for statewide implementation. The draft templates have been developed based on knowledge from the national and local level work on performance measurement and management that UCLA has undertaken for ADP over the last five years. The purpose for these dashboard templates was to create simple snapshots describing how counties and programs are performing with regard to the delivery of SUD services. These dashboards are intended to be used to drive decision-making processes to improve services and identify strong and weak performance at both the county and program levels.

Using data to improve services is a priority and efforts in California have been advancing over the past five years; however successful dissemination of data in general to the county and program levels has been challenging. The next step in

this process is piloting these draft dashboard templates with a few counties to gain practical experience as to their usefulness for the intended purpose. The piloting will occur in the last quarter of 2011 into 2012.

Template Development Process

Initial discussions for the development of these dashboards were based on identifying appropriate measures. Following recommendations at the national level, the focus was to start with indicators of identification, initiation, engagement, retention, and continuum of care measures. However, since the California Outcomes Measurement Service-Treatment (CalOMS-Tx) is the only statewide data system available to populate the dashboards and does not contain service encounter level data, measures were necessarily restricted to only those that could be captured using admission and discharge data. Measures were ultimately determined through multiple discussions with ADP as well as through consultation with Treatment Research Institute.

The next step was to determine how to convey the data output in a simple, easy to interpret form. A comprehensive review of dashboards used in various fields was conducted. It was determined that the use of percentages and proportions was the most common and conducive for the purposes of these dashboards. Setting benchmarks to provide context to the output is necessary as well. Consistent with practices in other states, and discussions with stakeholders, it was determined that program level dashboards would be created for each treatment modality (detoxification, residential, outpatient, methadone maintenance), since performance can differ markedly depending on the type of services being delivered (e.g. time in treatment/retention should be longer for methadone maintenance than for detoxification). County level dashboards were also generated to capture “system” measures that may involve more than one treatment program (e.g. a continuity of care measure that captures transfers between detoxification and treatment). Program level dashboards could be utilized as a method to provide feedback of program specific performance between county administrators and their providers. The system level dashboard was developed to gain a snapshot at the county level to measure provider connectedness by modality (transfer rates). Benchmarks are set at the state average in order to maintain consistency across the counties.

Finally, determining the format and visual style in which to translate the data in a snapshot method became the next challenge. Several formats were identified utilizing differing visual aids in a simple manner. These ranged from dials, meter bars, gauges, basic grids and charts, 5-star systems, thumbs up/down, red light/green lights, etc. However, technology across each county varies and would likely create restrictions on the complexity of the graphics, including the use of colors. Therefore, a format comprised of using a black and white table with check marks “√”s and “X”s to indicate at-a-glance indicators as to whether the outcomes fall above or below the benchmark.

Program Level Dashboard Templates by Modality

Detoxification

Program Name: _____ County: _____

Program Sub-Category: _____ Reporting Period: _____ - _____

(Includes: Residential-Hospital and Non Hospital, Outpatient, NTP)

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts transferred to a different tx modality *(14 days post discharge)*					Over X%	
Pts who "completed detoxification"					Over X%	
Pts re-entering detox within 30 days of previous discharge					Under X%	
Number of admits/discharges in same day					Under X%	

(Note: include data only from clients who report a primary drug of choice of alcohol and/or methadone)

Residential

Program Name: _____ County: _____

Program Sub-Category: _____ Reporting Period: _____ - _____

(Includes: Short-term residential, Long-term residential)

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts in treatment at least 30 days*					Over X%	
Pts transferred to another tx modality (step down to outpatient)					Over X%	
Pts reporting primary drug abstinence** at discharge					Over X%	

Number of admits/discharges in same day					Under X%	

** exclude short term residential* data from the N
**abstinence is defined as 0 days used within the last 30 prior to discharge interview

Outpatient

Program Name: _____ County: _____

Program Sub-Category: _____ Reporting Period: _____ - _____

(Includes: Intensive outpatient, Day care rehabilitative)

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts in treatment at least 30 days					Over X%	
Pts in treatment over 90 days *(retention)*					Over X%	
Pts reporting primary drug abstinence** at discharge					Over X%	
Number of admits/discharges in same day					Under X%	

**abstinence is defined as 0 days used within the last 30 prior to discharge interview

Methadone Maintenance

Program Name: _____ County: _____

Reporting Period: _____ - _____

Performance Measure	N (Number Discharged)	**SCORE (%)**	Previous Report		State Benchmark (State Avg?)	
			%	√ / **X**	%	√ / **X**
Pts in treatment at least 30 days					Over X%	
Pts in treatment over 1 year						
Pts with Annual Updates					Over X%	
Number of admits/discharges in same day					Under X%	

System Level Dashboard by County

County: _____ Reporting Period: _____ - _____

Performance Measure	N (Number d/c's from program category)	SCORE (%)	Previous Report		State Benchmark (State Avg?)	
			%	√ / X	%	√ / X
Pts transferred from Detox to treatment modality (step down)					Over X%	
Pts transferred from Residential to other tx modality (step down)					Over X%	
Pts reporting primary drug abstinence** at discharge					Over X%	

(Note: exclude County under analysis from total N)
**abstinence is defined as 0 days used within the last 30 prior to discharge interview

Future Considerations for Dashboard Enhancement

In an effort to maintain progress on performance measurement and management, ongoing discussions have been pursued this past year at the state level on the next steps to enhance the CalOMS-Tx data system. Ideally, program level encounter data, as well as program and county level measures to monitor for integration of services into the broader health care system would allow for the CalOMS-Tx data system to populate dashboards addressing measures more in line with current Washington Circle performance measure recommendations (identification, engagement, retention, etc.) as well as healthcare reform priorities.

However, under the current budget constraints, developing dashboards and data sources to incorporate these types of measures may not be feasible. They may become more feasible in the future if the use of electronic health records becomes widespread among SUD treatment providers. In the meantime, while it may not be possible to immediately implement them, for planning purposes measures have been identified that would be useful in an "ideal" system. Each of the measures listed below require further discussion and additional progress in the field before they could be implemented as part of a performance dashboard. Key points for discussion around each are included. An overarching concern with all potential new measures is the need to minimize the reporting burden on counties and providers. Therefore the advantages of each measure will need to be weighed carefully against this burden.

Program level measures for consideration

- Proportion of pts screened for Co-Occurring Disorders
    - *Key discussion point:* there are a number of screeners for anxiety and depression disorders that could be used at this time .Addition of type of measure could indicate a general culture shift toward broader implementation of screening strategies and supportive means toward integrated SUD and Mental Health (MH) services.

- Proportion of pts tested for Human Immunodeficiency Virus (HIV) during treatment
    - *Key discussion point:* Currently CalOMS-Tx collects data on whether the patient was tested for HIV two times, at admission and discharge. If a patient answers "no" at admission but "yes" at discharge, it can be inferred that testing occurred during treatment. However, if the patient answers "yes" at admission it is not possible to know if the patient was tested during treatment or not. For performance purposes it may make sense to modify the discharge question to ask if testing occurred during treatment.

- Proportion of pts tested for Hepatitis C, sexually transmitted diseases (STD)
    - *Key discussion point:* data on Hepatitis C and STD diagnoses are only collected at admission. For performance purposes it may make sense to have a discharge question asking if testing occurred during treatment.
- Proportion of pts on (or offered) medication-assisted therapies (MAT) at the time of discharge
    - *Key discussion point:* MAT provokes mixed reactions across treatment providers, but leaders in the SUD field believe that offering MAT or at least referral for MAT should be required as an evidence-based practice. CalOMS-Tx does already record whether MAT is used, but determining an appropriate benchmark may be challenging, as "drug free" providers are likely to resist any benchmark above zero.

- Proportion of pts initiated into treatment
    - *Key discussion point:* Washington Circle defines this as two or more visits within the first 14 days for outpatient treatment, which would require encounter-level data that is currently unavailable. .

- Proportion of pts engaged into treatment within the first 30 days
    - *Key discussion point:* instituting this in accordance with the Washington Circle definition would require encounter-level data, which is currently unavailable. A proxy measure can be used based on current CalOMS-Tx data instead. The degree to which

encounter-level data would add value beyond this proxy measure is unknown.

- Proportion of pts with social connectedness/social support
    - *Key discussion point:* While social support is important in recovery, feedback from stakeholder meetings (e.g. SAPC planning meetings described in Section 2 and the California Alcohol and Drug Program Administrators Association (CADPAAC) Data and Outcome Committee meetings) suggest that the current definition is too imprecise for the measure to be used for performance purposes.

County level measures for consideration

- Proportion of programs with memorandum of understandings (MOUs) /partnerships with other programs
    - *Key discussion point:* Although a good indicator of integration and continuum of services, this measure is not currently collected, would need to be well defined, and may not be meaningful within smaller counties.

- Proportion of levels of care represented across the county
    - *Key discussion point:* Although a good indicator of continuum of services offered within the county, performance can be expected to differ sharply by county size.

- Proportion of programs that use data reports to make decisions
    - *Key discussion point:* This information is not currently collected and would need to be well defined, e.g. use of specific reports. Data reports would also need to be easily accessible; suggesting use of this measure should be revisited in the future but may be premature until dashboards are in use.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

The California Department of Alcohol and Drug Programs (ADP) is involved with suicide prevention efforts in the following ways.

1. ADP staff works in partnership with the California Department of Mental Health (DMH) Office of Suicide Prevention as a member of the advisory committee. The advisory committee provides input in the creation of the *California Strategic Plan on Suicide Prevention*.

2. Cultural and linguistic considerations are addressed at the national and local levels by way of providing assistance to limited or non-English speaking individuals.

In 2008, DMH published the *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. The Plan was developed through recommendations of an advisory committee consisting of experts on suicide prevention, survivors of suicide attempts and suicide loss, representatives of mental health consumer and family members organizations, legislators, providers, crisis centers, and others. Recommendations were developed through an intensive year-long process that also included multiple points of public input.

Concurrently, DMH established the Office of Suicide Prevention (OSP) to oversee dissemination and implementation of the Plan and to serve as a statewide resource center. The Plan includes four Strategic Directions and 38 recommended actions at the state and local levels. The Plan presents detailed, California-specific data and statistics as well as information about best practices that address specific populations and settings. It identifies populations at particularly high risk of suicide, including veterans and service members, lesbian, gay, bi-sexual, transgender, and questioning (LGBTQ) youth, and older adults.

Since its publication, the Plan has been used extensively for state and local planning purposes, and implementation of recommendations is currently under way. The OSP has launched multiple partnerships and projects to address high risk populations identified in the Plan, particularly veterans, service members, and their families. The OSP has also done extensive outreach and technical assistance to facilitate Plan implementation. Counties have actively used the Plan to design local projects.

The Plan was used as a blueprint for a $24 million statewide project on suicide prevention funded under the Mental Health Services Act; this project will begin implementation later this summer. The DMH anticipates updating the Plan, which is three years old this summer, through an extensive stakeholder process and assessment of activities that have occurred since its publication within the next two to three years. Copies of the plan are available for downloading via the following hyperlink: Department of Mental Health Office of Suicide Prevention

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Working with Tribal Health Care Systems and Tribal Entities
In light of ongoing funding for the Indian Healthcare Improvement Act (IHCIA), and inclusion of behavioral health programs in it, the California Deparment of Alcohol and Drug Programs (ADP) requests technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA) with regard to how behavioral health services provided to the Tribes under IHCIA dovetails and/or overlaps with substance use disorder (SUD) services provided by the Substance Abuse Prevention and Treatment (SAPT) Block Grant as well as the role of State's in "meaningful consultation" with the tribes under Executive Order (EO) 13175.

Workforce Development (Recovery Support Services/Peer Specialists)
Technical assistance is needed on setting up a system of Recovery Support Services in order to identify additional resources necessary to build that component of the continuum of care and how to incorporate, in an effective and cost efficient manner, recovery/peer specialists.

Data Sharing with Other Health Agencies and Social Service Agencies
ADP requests technical assistance to determine the most efficient ways to share data with other agencies in order to improve service outcomes for all involved service systems while continuing to ensure the security, privacy, and confidentiality of the clients involved.

Health Information Technology (HIT)
ADP seeks technical assistance to prepare the State and counties to support the providers as they research and purchase HIT systems for the purposes of record keeping and information exchange.

Improvement of Data Systems to Comply with Health Care Reform
ADP seeks technical assistance to explore our options to respond to new requirements for outcome and performance measurement, and health information exchange as they emerge.

Capacity
ADP requests technical assistance to help California define "capacity" for our Drug and Alcohol Treatment Access Report (DATAR) as we are having difficulty defining outpatient capacity in particular. There are also issues, even for residential providers, about the number of beds for which they are licensed versus the funding they are receiving – is there enough funding to fill all the licensed beds.

Improving the Performance of the SUD System
ADP seeks technical assistance for providers and County director's on how to use data to produce more true "networks" of care, identify deficiencies in the service system and strategize how to address these shortcomings.

Identifying Evidence-Based Environmental and Community-Based Policies, Programs and Practices

More and more counties in California have moved toward incorporating environmental and community-based strategies in the ATOD prevention efforts yet there are a minimal number of evidence-based programs identified. ADP requests assistance in identifying policies, programs and practices that will meet SAMHSA's requirements to utilize evidence-based programs. Assistance was requested from CAPT in 2009, 2010 and 2011 in the form of a summary of other state's efforts.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Published in September, 2007, the Continuum of Services System Re-engineering (COSSR) Task Force Phase II Report specifically describes the California Department of Alcohol and Drug Programs (ADP's) efforts to support and help strengthen existing consumer and family networks. ADP established the COSSR Task Force to assist the department in examining the current alcohol and other drug (AOD) services delivery system and to develop a plan for overall system change. One of the primary goals was to work with stakeholders, including individuals and family members, to promote recovery support. Because of the re-engineering effort's significant impact on the current AOD system of services, it was important to invite individuals and families who could represent their views.

The report emphasizes the Continuum of Services model based on the concept that AOD addiction and dependence is a chronic illness. The COSSR builds on work in 2004 by the Institute for Research, Education and Training in Addictions, who facilitated a leadership group to examine this assertion. The group established principles of care for development of new systems to treat addiction, including the overarching principle that: *"the individual (family and community) receiv(es) the right prevention, intervention, and/or treatment and support, at the right level, for the right period of time by the right practitioner, agency or sponsor, every time… In this principle will be the assurance of quality, efficiency and accountability to all stake holders and the assurance that every individual has the best opportunity to achieve wellness and recovery."*

Certainly, the value of involving individuals and families is prominent in the COSSR report as evidenced by the following image depicting the model:

In California's governance structure for alcohol and drug programs, all federal funds administered by the state are provided to counties who are responsible for

delivering services. They either provide the services directly or sub-contract through providers. Consequently, county alcohol and drug agencies insure that individuals in recovery and family members are utilized in the development and implementation of recovery support services. When necessary, ADP offers technical assistance to support these goals. Specifically, ADP provides training in Culturally and Linguistically Appropriate Services (CLAS) competencies, including target populations, and offers technical assistance by department staff to ensure counties have the resources they need to actively engage clients and families in their services and programs. ADP also insures oversight and accountability through compliance and monitoring activities of the Negotiated Net Amount (NNA) contract.

ADP sponsors statewide meetings through a contract with the County Alcohol and Drug Program Administrators Association of California (CADPAAC). These meetings are convened to discuss statewide policy and program matters. These meetings are quarterly and include topics that address how to promote opportunities to proactively engage individuals and family members in treatment planning and shared decision making.

Eight Constituent Committees were established to advise and assist the ADP's Director and Executive Staff in developing strategies to plan and support culturally-competent alcohol and other drug abuse, prevention, and recovery services. The purpose of these committees is to improve and expand alcohol and drug services for California's diverse population. Committee members provide important input on involvement of individuals and families in an effort to support and help strengthen existing consumer and family networks. The committees provide a two-way communication with key constituent groups and provide alcohol and drug services knowledge, geographic area representation, and community involvement. The chair of each Constituent Committee serves as a member of the Director's Advisory Council (DAC). The following is a list of the committees:

- African-American Constituent Committee
- Aging Constituent Committee
- Asian/Pacific Islander Constituent Committee
- Disability Constituent Committee
- Lesbian, Gay, Bisexual & Transgender Constituent Committee
- Latino Constituent Committee
- Native American Constituent Committee
- Women's Constituent Committee

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

The Department of Alcohol and Drug Programs (ADP) is exploring options for using Interactive Communication Technologies (ICT) for a variety of uses while also ensuring the means for preserving the security, privacy and confidentiality of the data provided using those technologies. The following summarizes the Department's efforts to date:

To date, ADP has used ICT for the California Access to Recovery Effort (CARE). The CARE program utilizes the Life:WIRE system to support clients' recovery. Life:WIRE is an interactive communication technology that uses text-messaging and email to engage, track and motivate clients. Access to Recovery (ATR) providers use Life:WIRE to remind clients of appointment times, ask questions to evaluate progress/status, and reinforce positive behaviors. Using a computer, counselors or case manager's log on to a secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant website to set up the time, frequency, and nature of text messages or emails to individual or multiple clients in their caseload. Customized questions prompt a single digit reply from the client via their cell phone, which in turn activate an automated response and/or notify the counselor if the client's reply is outside a prescribed range. The Life:WIRE system generates real-time data so that providers can continuously monitor client progress and analyze client responses.

ADP will continue to support Life:WIRE through the vendor, for the duration of the grant, which is projected to continue through 2014. ADP will continue to explore options for additional ICT applications and the support they require through the current transition period.

To encourage provider use of Life:WIRE, ADP includes Life:WIRE as an allowable service under ATR. Through an ATR voucher, providers are reimbursed monthly for each client whom they set up with a Life:WIRE account and they are also reimbursed for the one-time set up fee charged by Life:WIRE. ADP will continue to explore options for additional ICT applications in the future.

ADP meets on a regular basis with members of the behavioral health field to enhance preparedness for implementation of health care reform. We will work with behavioral and general health systems to explore effective use of ICT to support behavioral health integration.

At this time, ADP does not plan to utilize Life:WIRE to collect data for CARE program evaluation. However, individual providers have the ability to use Life:WIRE data to evaluate and help inform their clients' treatment and progress. ADP will continue to explore options for use of ICT applications to collect program evaluation at the individual and provider levels in the future. ADP will continue to explore measures and data collection options for promoting and judging use and effectiveness of ICT applications in the future.

In addition, ADP's Prevention Resource Center is looking into various forms of social media/marketing such as YouTube, FaceBook, Twitter, and Google+. These media tools will enable ADP to help advance alcohol, tobacco, and other drugs (ATOD) prevention and health reform by providing real time information on funding opportunities, news sources, and AOD prevention initiatives identified by the SAPT

Block Grant, SAMHSA, the Office of National Drug Control Policy (ONDCP), and other agencies and organizations.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

In carrying out its mission "to lead efforts to reduce alcoholism, drug addiction, and problem gambling in California by developing, administering and supporting prevention, treatment, and recovery programs," the California Department of Alcohol and Drug Programs (ADP) seeks collaboration and advice from many State departments and constituent groups, including the following:

California Department of Health Care Services (DHCS)
DHCS is the lead state department for expanding healthcare in California under the Affordable Care Act. DHCS and ADP are departments within the California Health and Human Services Agency. This creates an organizational partnering on overarching policies and programs such as health care reform and the SAMHSA block grant. Both departments are also members of the State Interagency Group (SIT) who meet monthly at the executive operational level (deputy director) to work on collaborative policy initiatives and projects. DHCS agrees to continue to consult with ADP on the development of benefits in the expanded Medicaid population.

Administrative Office of the Courts (AOC)
The AOC is the staff agency to the Judicial Council of California, the policymaking body of the state court system. It is responsible for a variety of programs and services to improve access to a fair and impartial judicial system. As such, the AOC addresses policy matters concerning substance use disorders diversion programs. AOC is a member of the SIT. AOC agrees to continue to consult with ADP on related matters.

California Department of Education (CDE)
CDE is a California agency that oversees public education. The department oversees funding and testing, and holds local educational agencies accountable for student achievement. Its stated mission is to provide leadership, assistance, oversight, and resources (via teaching and teaching material) so that every Californian has access to a good education. Also a member of the SIT and GPAC, CDE is poised to continue assist ADP in the development of programs and services that address related goals in the block grant including, but not limited to prevention, early intervention and treatment of substance use disorders.

California Department of Social Services (CDSS)
CDSS is a state department for many of the programs defined as part of the social safety net and is also a part of the California Health and Human Services Agency. Federal and State funds for adoptions, foster care, aid to the disabled, family crisis counseling, subsistence payments to poor families with children, child welfare services and many other efforts are distributed through this department. CDSS is a member of the SIT and the Green Book, an interagency group that addresses domestic violence and trauma issues; and agrees to continue to collaborate with ADP on related matters.

California Department of Public Health (CDPH)
The mission of the CDPH is to optimize the health and well-being of the people in California, primarily through population-based programs, strategies, and initiatives. CDPH's goals are to achieve health equities and eliminate health disparities; eliminate

preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization. CDPH is working toward these goals through its programmatic and operational support activities and in collaboration with local health departments and other organizations throughout the State. CDPH is a member of the SIT, GPAC and the SEW and will continue to partner with ADP on related matters.

California Department of Mental Health (CDMH)
The California Department of Mental Health, entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, and culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services. CDMH is also part of the California Health and Human Services Agency and will continue to partner with ADP on related matters.

Director's Advisory Council (DAC)
Established in 1993 to ensure the delivery of quality alcohol, drug abuse, and problem gambling services in California. Members include ADP leaders, judges, directors of statewide provider organizations, the president of the County Alcohol and Drug Program Administrator's Association of California (CADPAAC), and the chairs of the eight constituency committees.

Governor's Prevention Advisory Council (GPAC)
GPAC coordinates the State's strategic efforts to reduce the incidence and prevalence of inappropriate alcohol, tobacco and other drug (AOD) use by youth and adults. Members are appointed by the Governor and include key administrators from major state agencies involved with prevention issues, funding, and/or program-level support.

Problem Gambling Advisory Group
The purpose of the Problem Gambling Advisory Group is to discuss priorities and strategies for educating and training individuals engaged in problem gambling-related issues. The Advisory Group is a valuable forum for collaboration among state regulating agencies, gambling-industry representatives, educators, researchers, and advocates for problem gambling issues.

County Alcohol and Drug Program Administrators Association of California, Inc. (CADPAAC)
CADPAAC is an organization of county alcohol and drug program administrators dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs.

Constituent Committees

The eight Constituent Committees were established to advise and assist the ADP Director and Executive Staff in developing strategies to plan and support culturally-competent alcohol and other drug abuse, prevention, and recovery services. The purpose of these committees is to improve and expand alcohol and drug services for California's diverse population.

Committee members provide important input and two-way communication with key constituent groups and provide alcohol and drug services knowledge, geographic area representation, and community involvement. The chair of each Constituent Committee serves as a member of the Director's Advisory Council (DAC).

- African-American Constituent Committee
- Aging Constituent Committee
- Asian/Pacific Islander Constituent Committee
- Disability Constituent Committee
- Lesbian, Gay, Bisexual & Transgender Constituent Committee
- Latino Constituent Committee
- Native American Constituent Committee
- Women's Constituent Committee

External Stakeholders

- California Association of Addiction Recovery Resources (CAARR)
- California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)
- California Association of Alcoholism and Drug Abuse Counselors (CAADAC)
- California Association of Drinking Driver Treatment Programs (CADDTP)
- California Opioid Maintenance Providers (COMP)
- County Alcohol and Drug Program Administrators Association of California (CADPAAC)
- National Council on Alcoholism and Drug Dependence, Sacramento Region Affiliate (NCADD)

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system, some of which are described below:

Governor's Prevention Advisory Council (GPAC)
The Governor's Prevention Advisory Council coordinates the State's efforts to reduce the incidence and prevalence of inappropriate alcohol, tobacco and other drug use by youth and adults. Members are appointed by the Governor and include key administrators from major state agencies involved with prevention issues, funding, and/or program-level support.

County Alcohol and Drug Program Administrators Association of California (CADPAAC)
CADPAAC is an organization of county alcohol and drug program administrators dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs. In addition, this body represents California's 58 county/sub-state planning areas.

Director's Advisory Council (DAC)
The Director's Advisory Council was created in 1993 to ensure the delivery of quality alcohol, drug abuse, and problem gambling services in California. Members include ADP leaders, judges, directors of statewide provider organizations, the president of the County Alcohol and Drug Program Administrators Association of California, and the chairs of the eight constituency committees.

Constituent Committees
The eight Constituent Committees were established to advise and assist ADP's Director and Executive Staff in developing strategies to plan and support culturally-competent alcohol and other drug abuse, prevention, and recovery services. The purpose of these committees is to improve and expand alcohol and drug services for California's diverse population. The eight committees are; the African-American Constituent Committee, the Aging Constituent Committee, the Asian/Pacific Islander Constituent Committee, the Disability Constituent Committee, the Lesbian, Gay, Bisexual and Transgender Constituent Committee, the Latino Constituent Committee, the Native American Constituent Committee, and the Women's Constituent Committee

Narcotic Treatment Programs Advisory Committee (NTPAC)
The Narcotic Treatment Programs Advisory Committee meets to discuss emerging issues and provide information regarding the regulatory and policy issues associated with opiate treatment in California. Membership of the NTPAC is by invitation from the Director of ADP. Committee members are selected on the basis of their NTP knowledge and expertise and commitment to ensuring safe access to replacement narcotic therapies.

External Stakeholder Groups
ADP seeks collaboration and advice from many stakeholder groups as well, including; the California Association of Addiction Recovery Resources (CAARR), the California

Association of Alcohol and Drug Program Executives, Inc. (CAADPE), the California Association of Alcoholism and Drug Abuse Counselors (CAADAC), the California Association of Drinking Driver Treatment Programs (CADDTP), the California Opioid Maintenance Providers (COMP), the County Alcohol and Drug Program Administrators Association of California (CADPAAC), and the National Council on Alcoholism and Drug Dependence, Sacramento Region Affiliate (NCADD).

In addition, ADP's Acting Director, Michael S. Cunningham, serves as a member of the California Mental Health Planning Council (CMHPC). CMHPC is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

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Table 11 List of Advisory Council Members

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Start Year: 2012

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

The application strongly encourages States to expand and use the same advisory council required under the Mental Health Services Block Grant to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders. California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system, which are described in Section O– State Behavioral Health Advisory Council. At this time, the California Department of Alcohol and Drug Programs elects to continue to use existing advisory groups and to decline to use the same advisory council required under the Mental Health Services Block Grant but may consider it in the future if the composition of its membership is expanded to include more representation from the substance use services system.

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IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year: 2012

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	25	
Individuals in Recovery (from Mental Illness and Addictions)	7	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	14	56%
State Employees	7	
Providers	3	
Leading State Experts	1	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	11	44%

Footnotes:

The application strongly encourages States to expand and use the same advisory council required under the Mental Health Services Block Grant to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders. California has a long-standing array of substance use service system disorder planning bodies, advisory panels, constituent and stakeholder groups to help plan and implement its publicly funded service system, which are described in Section O– State Behavioral Health Advisory Council. At this time, the California Department of Alcohol and Drug Programs elects to continue to use existing advisory groups and to decline to use the same advisory council required under the Mental Health Services Block Grant but may consider it in the future if the composition of its membership is expanded to include more representation from the substance use services system.

IV: Narrative Plan

P. Comment On The State Plan

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Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Opportunities for public input into the State's planning process during the year preceding the development and after submission of the application at both the State and county levels include:

1. The Director's Advisory Council (DAC) advises the Director on AOD program and policy issues. The DAC is responsive to critical issues from the criminal justice field, counties and the larger alcohol and drug field. Members identify barriers to access for underserved populations and provide feedback to the communities they represent. Stakeholders identify and discuss issues and build consensus in major policy areas that impact the alcohol and other drug service systems and clients. The DAC includes eight constituent committees that represent a broad spectrum of the State's population to ensure appropriate services for the Californians that they represent. The DAC is comprised of the presidents of statewide AOD provider organizations, county alcohol and drug program administrators, and the chair of each constituent committee (African American; Aging; Asian, Pacific Islander; Disability; Lesbian, Gay, Bisexual, Transgender; Latino; Native American; and Women). The DAC provides a vehicle to communicate with and motivate all Californians to be involved in alcohol and drug policy issues; its meetings are open to the public.

2. ADP staff regularly meets with CADPAAC to update members on federal, State, and other funding requirements that impact the alcohol and drug field. ADP staff works in collaboration with CADPAAC staff and *ad hoc* committees to discuss policy, allocation methodologies, the equitable distribution of funds consistent with federal and State requirements, and other issues affecting State/county administration of alcohol and other drug programs and services.

3. The legislative budget hearing process provides a broad-based public forum for discussion and revision of proposed expenditures of both federal block grant and State general funds. The budget hearing process invites and welcomes input on AOD concerns (i.e., funding constraints, decreases, increases, etc.) from various constituent groups, county alcohol and drug program administrators, provider organizations, consumers, and any interested California citizen.

4. ADP forms various workgroups and task forces as needed to address current and emerging issues. The workgroups include representatives from CADPAAC, DAC, program executives, other social services systems, constituents/clients of the target population, and individuals with a wide variety of expertise in the related area. Examples of such workgroups include the: Offender Treatment Advisory Group, Fiscal Workgroup, Drug Medi-Cal Workgroup, Licensing and Certification Regulations Workgroup, and COSSR Task Force.

5. External constituent groups that meet with, or invite participation from, ADP staff are the California Prevention Collaborative, California Organization of Methadone Providers, DUI Advisory Workgroup, High Rate Underage Users Workgroup,

Counselor Certification Oversight Workgroup, Counselor Certification Organizations Workgroup, and the California Association of Alcohol and Drug Program Executives.

Copies of the Substance Abuse Prevention and Treatment Block Grant application are distributed to the: 1) Library of Congress, Washington, D.C.; 2) Governor's Office of Planning and Research; 3) Depository Libraries; 4) State Library; 5) State Archivist; 6) Research Librarian, Council of State Governments; and 7) ADP's Resource Center, which distributes copies of the application upon request. Each year, the draft application is posted on ADP's Web site for public review and comment before the application is submitted to the Substance Abuse and Mental Health Services Administration.

Exhibit A

Reimbursement Strategy, Approach and Methodology

Encounter based reimbursement

The California Outcomes Measurement Service (CalOMS) system does not currently collect unique client level encounter data. There will be a fiscal impact to consider at both the state and county level to implement modifications to the system to capture such data.

The California Department of Alcohol and Drug Programs (ADP) is interested in using the Washington Circle Measures of Access, Initiation and Engagement as adjuncts to NOMS data, because they utilize administrative data rather than client-reported data, which may be influenced by recall, cultural differences and pending court decisions. Although we don't currently collect encounter data in our CalOMS data system, through California's Drug Medi-Cal Billing System, we have information on dates of services for Drug Medi-Cal funded outpatient clients. From these data, we can calculate percent of client's initiation services and engaging in services beyond initiation. We can also calculate the median number of engagement services received by our clients.

California will need additional resources to change its reporting system and train counties and providers in its use. Counties and providers will need additional resources to change their data gathering and reporting systems. Changes of such magnitude take time to implement, and then it takes time to collect the data in order to report it.

Grant/Contract reimbursement

ADP uses SAPT Block Grant funds to contract with the University of California, San Francisco (UCSF) and ONTRACK Program Recourses, Inc. These contractors provide ADP with expert consultation in the medical and cultural competency fields necessary to complete ADP's mission and strategic vision.

UCSF provides a licensed physician (serving as Medical Director), a Research Assistant, and a Consultant. ADP uses SAPT Block Grant funds to fund the UCSF contract for each of the three State Fiscal Years from July 1, 2011 through June 30, 2014. UCSF invoices ADP monthly for the direct personal, operating and other expenses and indirect expenses of providing services under the contract. In addition to an invoice, UCSF provides ADP with quarterly written activity reports.

Through a statewide TA Contract, ONTRACK Program Resources, Inc., assists ADP in providing culturally and linguistically appropriate services (CLAS) in accordance to CLAS standards and other cultural competence best practice models. ADP uses SAPT Block Grant funds to fund the ONTRACK Program Resources , Inc., for three calendar years from January 1, 2011 through December 31, 2013. ONTRACK Program Resources, Inc. invoices ADP monthly for the expenses of providing services under the contract. Additionally, ONTRACK Program Resources, Inc., provides monthly progress

reports of services provided under the contract. The reports include the number of individuals served, marketing strategies, problems encountered in achieving or failing to achieve proposed objectives, and methods employed to resolve stated problems.

Risk based reimbursement
ADP does not utilize a risk based reimbursement strategy at this time.

Innovative financing strategy
ADP is examining performance-based program data as a basis for evaluating program performance and allocating Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to counties. For example, client's Time in Treatment; Completion of Treatment/Recovery Plan Goals; and Abstinence from Use of Primary Drug of Choice for a certain length of time are being evaluated for further use to allocate a portion of the SAPT Block Grant to California counties. The goal is to allocate more SAPT Block Grant funds to counties based on their achievement of the performance-based indicators. This process should provide an incentive to improve and expand capacity of substance use disorder programs.

ADP anticipates implementing the new performance-based methodology to allocate a portion of Federal Fiscal Year 2013 SAPT Block Grant funds to counties in State Fiscal Year 2012-2013. In subsequent years, ADP may apply the new allocation methodology to a larger portion of the SAPT Block Grant funds.

Other reimbursement strategy
ADP does not currently utilize other reimbursement strategies.

Exhibit B: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

ABC	Alcoholic Beverage Control
ACA	Affordable Care Act
ACTION	Adopting Changes to Improve Outcomes Now
ADA	Americans with Disabilities Act
ADAM	Arrestee Drug Abuse Monitoring
ADP	Alcohol and Drug Programs, Department of
AG	Attorney General
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
ASC	Accredited Standards Committee
ASI	Addiction Severity Index
ATOD	Alcohol, Tobacco and Other Drugs
ATR	Access to Recovery
BAC	Blood Alcohol Content
BHI	Behavioral Health Integration
CAARR	California Association of Addiction Recovery Resources
CADCA	Community Anti-Drug Coalitions of America
CADDS	California Alcohol and Drug Data System
CADPAAC	County Alcohol and Drug Program Administrators Association of California
CalOMP	California Outcome Monitoring Program
CalOMS-Pv	California Outcomes Measurement Service-Prevention
CalOMS-Tx	California Outcomes Measurement Service-Treatment
CalSTARS	California State Accounting and Reporting System
CalWORKS	California Work Opportunity and Responsibility to Kids
CARE	California Access to Recovery Effort
CARS	Center for Applied Research Solutions
CASA	National Center on Addiction and Substance Abuse
CASBIRT	California Screening, Brief Intervention, and Referral to

Exhibit A: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

	Treatment
CATES	California Addiction Training & Education Series
CCC	California Conservation Corps
CCQI	Cultural Competency Quality Improvement
CCR	California Code of Regulations
CDCR	California Department of Corrections & Rehabilitation
CDE	California Department of Education
CDPH	California Department of Public Health
CDPH-OA	California Department of Public Health-Office of Aids
CDVA	California Department of Veterans Affairs
CFNLP	California Friday Night Live Partnership
CEED	Coverage Expansion and Enrollment Demonstration
CFR	Code of Federal Regulations
CHHS	California Health and Human Services Agency
CHIS	California Health Interview Survey
CHKS	California Healthy Kids Survey
CIMH	California Institute for Mental Health
CLAS	Culturally and Linguistically Appropriate Services
CMHPC	California Mental Health Planning Council
CMI	California Methamphetamine Initiative
CMS	Centers for Medicaid and Medicare Services
COD	Co-Occurring Disorders
COJAC	Co-Occurring Joint Action Council
COS	Continuum of Services
COSSR	Continuum of Services System Re-engineering
CPC	California Prevention Collaborative
CPCA	California Primary Care Association
CPI	Community Prevention Initiative
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment

Exhibit A: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

CSS	California Student Survey
DAC	Director's Advisory Council
DATA 2000	Drug Addiction Treatment Act of 2000
DATAR	Drug and Alcohol Treatment Access Report
DCR	Day Care Rehabilitative
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DEA	Drug Enforcement Administration
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMH	Department of Mental Health
DMV	California Department of Motor Vehicles
DOF	California Department of Finance
DPH-OA	Department of Public Health – Office of Aids
DUI	Driving-Under-the-Influence
DUIP	Driving-Under-the-Influence Program
EAU	Excessive Alcohol Use
EBP	Evidence-Based Practices
ED	Emergency Department
EDD	Employment Development Department
EIS	Early Intervention Services
ENCAL	Evaluation Services to Enhance the Data Management System in California
EPSDT	Early and Periodic Screening Diagnosis and Treatment
FASD	Fetal Alcohol Spectrum Disorders
FDA	Federal Drug Administration
FFY	Federal Fiscal Year
FY	Fiscal Year
FNL	Friday Night Live
FOTP	Female Offender Treatment Program
FPL	Federal Poverty Level

Exhibit A: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

FQHCs	Federally Qualified Health Centers
GPAC	Governor's Prevention Advisory Council
HCCI	Health Care Coverage Initiative
HHS	U.S. Department Of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinic Health
HIV	Human Immunodeficiency Virus
HRU	High Risk Use
IBHP	Integrated Behavioral Health Project
ICD	International Statistical Classification of Diseases
IDU	Injection Drug Users
IFB	Invitation for Bid
IHCIA	Indian Health Care Improvement Act
IMD	Inpatient Methadone Detoxification
IOM	Institute of Medicine
IPI	Integration Policy Initiative
IPRP	Independent Peer Review Project
ISAP	Integrated Substance Abuse Programs
IVDU	Intravenous Drug User
LAPD	Los Angeles Police Department
LASBIRT	Los Angeles Screening, Brief Intervention, and Referral to Treatment
LCSW	Licensed Clinical Social Worker
LGBT	Lesbian, Gay, Bisexual, and Transgender
LIHP	Low-Income Health Programs
MBA	Minimum Base Allocation (Counties)
MCE	Medicaid Coverage Expansion
MFT	Marriage and Family Therapist
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MHSA	Mental Health Services Act

Exhibit A: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

MIGS	Members in Good Standing
MOE	Maintenance of Effort
MOU	Memo of Understanding
NAR	Needs Assessment Report
NASADAD	Nation Association of State Alcohol/Drug Abuse Directors
NCE	No-Cost Extension
NCTIC	National Center for Trauma Informed Care
NIATx	Network for the Improvement of Addiction Treatment
NNA	Negotiated Net Amount
NNAC	Negotiated Net Amount Contract
NOMs	National Outcome Measures
NPI	National Provider Identifier
NPN	National Prevention Network
NREPP	National Registry of Evidence-based Programs and Practices
NSDUH	National Survey on Drug Use and Health
NTP	Narcotic Treatment Program
OARA	Office of Applied Research and Analysis
OCJC	Office of Criminal Justice Collaboration
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMD	Outpatient Methadone Detoxification
ONDCP	Office of National Drug Control Policy
ONTRACT	ONTRACT Program Resources, Inc.
OSHPD	Office of Statewide Health Planning and Development
OWPS	Office of Women's and Perinatal Services
PADS	Prevention Activities Data System
PEI	Prevention and Early Intervention
PES	Perinatal Environmental Scan
PHI	Protected Health Information
PIRE	Pacific Institute for Research and Evaluation

Exhibit A: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

PMB	Performance Management Branch
PPACA	Patient Protection and Affordable Care Act
PPC	Patient Placement Criteria
PSATTC	Pacific Southwest Addiction Technology Transfer Center
PSD	Program Services Division
PSN	Parolee Services Network
PTSD	Post Traumatic Stress Disorder
RC	Resource Center
RFP	Request for Proposal
RRHP	Resident-Run Housing Program
SACPA	Substance Abuse and Crime Prevention Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Student Assistance Program
SAPT	Substance Abuse Prevention and Treatment
SAPTBG	Substance Abuse Prevention and Treatment Block Grant
SARC	Substance Abuse Research Consortium
SASSI	Substance abuse Subtle Screening Inventory
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDFSC	Safe and Drug-Free Schools and Communities
SEOW	State Epidemiological Outcomes Workgroup
SEW	State Epidemiological Workgroup
SFY	State Fiscal Year
SGF	State General Fund
SIG	State Incentive Grant
SIM	System Improvement Model
SIT	State Interagency Team
SNAP	State Needs Assessment Planning
SPDs	Seniors and Persons with Disabilities
SPF	Strategic Prevention Framework

Exhibit A: Acronyms Used in the SAPT Block Grant Application (FFY 2012)

SPF-SIG	Strategic Prevention Framework - State Incentive Grant
SSA	Single State Agency
STAKE	Stop Tobacco Access to Kids Enforcement (Act)
STD	Sexually Transmitted Disease
STNAP	State Treatment Needs Assessment Program
SUD	Substance Use Disorder
SUS	Substance Use Services
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TB	Tuberculosis
TC	Trauma Center
TCS	Tobacco Control Section
TEDS	Treatment Episode Data Specifications
TMAC	Telephone Monitoring and Adaptive Counseling
UCLA	University of California, Los Angeles
UCLA-ISAP	University of California, Los Angeles—Integrated Substance Abuse Programs
UPPL	Uniform Accident and Sickness Policy Provision Law
VA	United States Department of Veterans Affairs
VAI	Veterans Awareness Initiative
VHA	Veterans Health Administration
WestCAPT	Western Center for the Application of Prevention Technologies
WSN	Women's Services Network
YSR	Youth Situational Report